DOCUMENT RESUME

ED 336 456 UD 028 200

AUTHOR	Oyemade, Ura Jean, Ed.; Brandon-Monye, Deloris, Ed.
TITLE	Ecology of Alcohol and Other Drug Use: Helping Black High-Risk Youth. Proceedings of the Howard University School of Human Ecology Forum (Washington, D.C., October 26-27, 1987). OSAP Prevention Monograph-7.
INSTITUTION	Alcohol, Drug Abuse, and Mental Health Administration (DHHS/PHS), Rockville, MD. Office for Substance Abuse Prevention.
REPORT NO	(ADM)-90-1672
PUB DATE	90
NOTE	245p.
PUB TYPE	Collected Works - Conference Proceedings (021)
EDRS PRICE	MF01/PC10 Plus Postage.
DESCRIPTORS	*Alcohol Abuse; Alcohol Education; *At Risk Persons; Black Culture; *Black Youth; Cocaine; Conference Proceedings; Cultural Influences; *Drug Abuse; Etiology; Family Environment; Incidence; Models; Prevention; Substance Abuse; *Urban Environment

ABSTRACT

Five plenary session presentations and summaries of 10 panel sessions held at a forum entitled "The Ecology of Substance Abuse: Toward Primary Prevention among High-Risk Youth" are provided in this document, which focuses on black youth at high risk for alcohol and drug problems. Experts describe a comprehensive ecological approach to addressing antecedent and concomitant factors related to alcohol and other drug use among black high-risk youth. Plenary session presentations are: (1) "Implications of Alcohol and Other Drug Use for Black America" (B. J. Primm); (2) "The Second Cocaine Epidemic" (D. F. Musto); (3) "Prevention Models Targeted to Black Youth at High Risk for Alcohol and Other Drug Problems" (V. L. Smith); (4) "Primary Prevention from a Public Health Perspective: The Realities of the Urban Environment" (R. Tuckson); and (5) "An Ecological Model for Prevention of Drug Use" (C. H. Edwards). Panel session summaries are: (1) "The Incidence of Alcohol and Other Drug Use"; (2) "Family, Cultural, and Environmental Risk Factors Related to Alcohol and Other Drug Use among Black Youth at High Risk"; (3) "The Interaction of Health and Nutrition"; (4) "International Dimensions of Drug Trafficking"; (5) "Pharmaceutical Industry: Friend or Foe?"; (6) "Systemic Factors Related to Alcohol and Other Drug Use"; (7) "Prevention Models for Black Youth at High Risk: Family and Religion"; (8) "Prevention Models for Black Youth at High Risk: Education and Media"; (9) "Prevention Models for Black Youth at High Risk: Industry and Government"; and (10) "Prevention Models for Black Youth at High Risk: Health Care and Civic Organizations." Three appendices provide supplemental information about the forum as well as an Office of Substance Abuse Prevention fact sheet on alcohol and other drug abuse among African Americans in the United States. (SLD)

ED 336456

OSAP Prevention Monograph-7

ECOLOGY OF ALCOHOL AND OTHER DRUG USE: NEEDS OF BLACK HIGH-RISK YOUTH

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OSAP Prevention Monograph–7

ECOLOGY OF ALCOHOL AND OTHER DRUG USE: HELPING BLACK HIGH-RISK YOUTH

Proceedings of the Howard University, School of Human Ecology, Human Ecology Forum, "The Ecology of Substance Abuse: Toward Primary Prevention Among High-Risk Youth"

Sponsors:

Office for Substance Abuse Prevention

Howard University, School of Human Ecology

Washington, DC, Department of Human Services, Commission on Public Health, Alcohol and Drug Abuse Services Administration

District of Columbia Public Schools

Howard University Institute for Substance Abuse and Addiction

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

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5600 Fishers Lane
Rockville, MD 20857

OSAP Prevention Monographs are prepared by the divisions of the Office for Substance Abuse Prevention (OSAP) and published by its Division of Communication Programs. The primary objective of the series is to facilitate the transfer of prevention and intervention technology between and among researchers, administrators, policymakers, educators, and providers in the public and private sectors. The content of state-of-the-art conferences and reviews of innovative or exemplary programming models and of evaluative studies are important elements of OSAP's information dissemination mission.

This monograph is based on papers and discussion from the Howard University, School of Human Ecology, Human Ecology Forum, "The Ecology of Substance Abuse: Toward Primary Prevention Among High-Risk Youth," held in Washington, DC, October 26–27, 1987. The proceedings were compiled by the faculty of the School of Human Ecology at Howard University.

The presentations herein are those of the listed authors and may not necessarily reflect the opinions, official policy, or position of OSAP, the Alcohol, Drug Abuse, and Mental Health Administration, the Public Health Service, or the U.S. Department of Health and Human Services (DHHS).

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Library of Congress Catalog Card Number: 90-080509.
DHHS Publication # (ADM)90-1672
Printed 1990
OSAP Production Officer: Linda Franklin

Project Officer:
Addie J. Key, Division of Community Prevention and Training, OSAP

OSAP Prevention Monograph Series
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Foreword

Knowledge transfer within the alcohol and other drug (AOD) field is vitally important, especially in the rapidly evolving field of prevention. Service providers are anxiously awaiting news of innovative and promising methodologies so that they might apply them in their own programs.

Thus, the Office for Substance Abuse Prevention (OSAP) is pleased to publish this monograph that presents the proceedings of a conference sponsored by Howard University's School of Human Ecology in the fall of 1987. Black youth at high risk for AOD problems were the focus of the conference, and noted experts described a comprehensive, ecological approach to address the antecedent and concomitant factors related to alcohol and other drug use among Black high-risk youth.

Alcohol and other drug problems are America's most pressing social dilemma, and high-risk youth compose the most vulnerable population group for problems associated with their use. Multicultural youngsters are over-represented among high-risk youth and are also particularly vulnerable for certain related and very serious problems. These problems include precocious sexual behavior, teen pregnancy, infant mortality, truancy, dropping out of school, delinquency, and youth gang involvement. Therefore, a holistic approach is particularly important in programs targeted to high-risk youngsters.

Because traditional prevention programs are seldom appropriate for use with high-risk groups, several chapters in this monograph are devoted to identifying the special attributes and innovative approaches that are suitable and relevant for use with multicultural and other very vulnerable youths. It also covers coalition building and strategy development at the community level. Several exceptional programs from the Washington, DC, and Baltimore, MD, area are described.

Although conference participants were primarily focusing on Black youth in the Nation's capital, the information in this monograph is also relevant for high-risk practitioners in other large metropolitan areas. It will be useful to policymakers, researchers, program planners, and prevention activists at national, State, and local levels. Indeed, all who are interested in prevention among high-risk youth will find this monograph to be an important and up-to-date reference manual.

This publication is one in a series of OSAP monographs that are issued from time to time to communicate state-of-the-art information across the entire prevention spectrum. We hope these monographs will facilitate knowledge transfer and thereby improve prevention and intervention programs across the Nation.

Elaine M. Johnson, Ph.D., Director
Office for Substance Abuse Prevention

Preface

The Office for Substance Abuse Prevention (OSAP) and Howard University are pleased to publish this volume on the ecology of alcohol and other drug (AOD) use among Black high-risk youth. This report presents the proceedings from the Human Ecology Forum held at Howard University, in Washington, DC, October 26–27, 1987.

The conference provided a forum for sharing information from a broad spectrum of disciplines with the goal of formulating a definitive model for primary prevention focusing on Black high-risk youth. The Forum Planning Committee comprised faculty from each department of the School of Human Ecology, Howard University's Institute for Substance Abuse and Addiction, Washington, DC's Alcohol and Drug Abuse Services Administration and Public School System, and representatives from OSAP. The forum presentations include a wealth of knowledge from well-known and well-respected researchers, practitioners, law enforcement officials, representatives of the pharmaceutical industry, civic organizations and housing cooperatives, and Federal policymakers.

OSAP recognizes that AOD problem prevention and intervention program development and implementation are long-range comprehensive processes. The entire community and all its systems, including schools, parents and parent groups, civic groups, religious institutions and the clergy, health and social service agencies, law enforcement agencies and courts, other Government agencies, media groups, and business and industry, must be involved in the comprehensive effort to place people at less risk for the cluster of problems associated with AOD.

The forum addressed this need for a comprehensive approach by convening researchers and practitioners well versed in the dynamics of AOD intervention to work on an integrative, ecological model that would delineate a comprehensive primary prevention approach to this growing problem facing high-risk youth. The publication of this information in a single volume makes a significant contribution to the broad distribution of valuable prevention information to colleagues in the entire spectrum of alcohol and other drug use prevention programs.

OSAP wishes to express its appreciation to the many presenters whose valuable insights we have the benefit of and to the following people who guided the development of the forum: Dr. Ura Jean Oyemade-Bailey, chairperson of the

Forum Planning Committee, and Planning Committee members, Dr. Wilbur Atwell, Mr. Charles Avery, Ms. Deloris Brandon-Monye, Dr. Clarence Calbert, Ms. Donna S. D'Almeida, Dr. Lillian Holloman, Dr. Linus Hoskins, Dr. Fatma Huffman, Dr. Sherrill Ismail, Mr. William Johnson, Ms. Addie Key, and Dr. Velma LaPoint.

Gale A. Held
Director
Division of Community Prevention and Training
Office for Substance Abuse Prevention

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Forum Program

MONDAY, OCTOBER 26, 1987

Opening Address
"Implications of Alcohol and Other Drug Use for Black America"
Speaker: **Dr. Beny J. Primm,** Co-Founder and Executive Director, Addiction Research Treatment Center, Brooklyn, NY

Panel A
"The Incidence of Alcohol and Other Drug Use"
Moderator: **Dr. Wilbur Atwell,**
Comoderator: **Mr. Kevin McGowan,**
Panelist: **Dr. Edgar Adams,** *Director*, Division of Epidemiology and Statistical Analysis, National Institute on Drug Abuse, Rockville, MD
Mr. George McFarland, *Acting Chief*, Office of Information, Prevention, and Education, Alcohol and Drug Abuse Services Administration, Washington, DC
Dr. Tom Harford, National Institute on Alcohol Abuse and Alcoholism, Rockville, MD
Recorder: **Dr. Barbara Harland**

Panel B
"Family, Cultural, and Environmental Risk Factors Related to Alcohol and Other Drug Use Among Youth at High Risk"
Moderator: **Ms. Donna S. D'Almeida,**
Comoderator: **Mr. Keith Jackson,**
Panelist: **Dr. Wade Nobles,** Institute for the Advanced Study of Black Family Life and Culture, Oakland, CA
Dr. Jeffrey Swanson, Department of Psychiatry and Behavioral Sciences, University of Texas, Galveston, TX
Recorder: **Dr. Wilbert Wilson**

Panel C
"The Interaction of Health and Nutrition"
Moderator: **Dr. James Adkins**
Comoderator: **Mr. Sunday Ogbonna**
Panelists: **Dr. John Hathcock,** Food and Drug Administration, Washington, DC
Ms. Margaret Dean *Nutrition Coordinator,* Alcohol and Drug Abuse Services Administration—Office of the Administrator, DC Department of Human Services, Commission on Public Health, Washington, DC
Dr. Daphne Roe, Division of Nutritional Sciences, Cornell University, Ithaca, NY
Dr. Marla Reicks, Food and Drug Administration, Division of Nutrition, Washington, DC
Dr. Jeannette Johnson, Addiction Research Center, National Institute on Drug Abuse, Baltimore, MD
Recorder: **Dr. Enid Knight**

Luncheon Plenary Session
"The Second Cocaine Epidemic"
Convenor: **Dr. Ouida Westney,** *Associate Dean,* School of Human Ecology
Introduction: **Dr. Ura Jean Oyemade,** *Chair,* Department of Human Development and Forum Planning Committee
Speaker: **Dr. David F. Musto,** *Professor of Psychiatry and History of Medicine,* Yale University, New Haven, CT

Panel D
"International Dimensions of Drug Trafficking"
Moderator: **Dr. Linus Hoskins**
Comoderator: **Ms. Shirlie Gibson,**
Panelists: **Mr. Alan G. Ringgold,** Federal Bureau of Investigation, Washington, DC
Dr. Manuel Gallardo, Bureau of International Narcotics Matters, State Department, Washington, DC
Mr. Carl Jackson, *Special Agent,* Washington Field Division, Drug Enforcement Administration, Washington, DC
Recorder: **Dr. Elizabeth Brabble**

Panel E
"Pharmaceutical Industry: Friend or Foe?"
Moderator: **Dr. Frank Porter,**
Comoderator: **Ms. Catherine Joseph,**
Panelists: **Ms. Norma Stewart, R.Ph.,** *Chief,* Pharmaceutical and Medical Devices Control Division, Department of Consumer and Regulatory Affairs, Washington, DC
Mr. Arthur Chalker, *Manager of Government Relations,* E.I. DuPont Company, Wilmington, DE
Mr. Allen Duncan, *Deputy Associate Commissioner for Health Affairs,* Food and Drug Administration, Rockville, MD
Recorder: **Ms. Lydia Savage**

Panel F
"Systemic Factors Related to Alcohol and Other Drug Use"
Moderator: **Dr. Ura Jean Oyemade,**
Comoderator: **Ms. Beverly Johnson,**
Panelists: **Dr. Lewis King,** *Director,* Fanon Center for Research Development, Charles Drew University of Medicine and Science, Los Angeles, CA
Dr. Cheryl Sanders, *Assistant Professor of Christian Ethics,* School of Divinity, Howard University, Washington, DC
Dr. Douglas G. Glasgow, *Vice President,* National Urban League, Washington, DC
Dr. Alvis Adair, *Professor,* School of Social Work, Howard University, Washington, DC
Recorder: **Dr. Lillian Holloman**

Afternoon Plenary Session
"Controlling the Supply of Drugs"
Convenor: **Mr. William Johnson,** DC Public Schools
Introduction: **Dr. Elizabeth Brabble,** School of Human Ecology
Speaker: **Mr. Edward H. Jurith,** *Staff Director,* Select Committee on Narcotic Abuse and Control, U.S. House of Representatives, Washington, DC

TUESDAY, OCTOBER 27

Morning Plenary Session
"Prevention Models Targeted to Black Youth at High Risk for Alcohol and Other Drug Use"
Convenor: **Dr. Velma LaPoint,** *Assistant Dean,* School of Human Ecology
Introduction: **Ms. Addie Key,** *Public Health Advisor,* Office for Substance Abuse Prevention, Rockville, MD
Speaker: **Ms. Vivian L. Smith,** *Deputy Director,* Office for Substance Abuse Prevention, Rockville, MD
Presentation / Affirmation: **Youth,** Mayor's Youth Leadership Institute, Washington, DC

Panel G
"Prevention Models for Black Youth at High Risk: Family and Religion"
Moderator: **Dr. Hakim Rashid**
Comoderator: **Ms. Rouvenia Brock**
Panelists: **Ms. Addie Key,** Office for Substance Abuse Prevention, Rockville, MD
Dr. Omowale Amuleru-Marshall, Cork Institute on Black Alcohol and Drug Abuse, Morehouse School of Medicine, Atlanta, GA
Ms. Susan Meehan, *Special Assistant to the Administrator, ADASA, Director,* Project PARADE, Washington, DC
Recorder: **Dr. Sylvan Alleyne**

Panel H
"Prevention Models for Black Youth at High Risk: Education and Media"
Moderator: **Mr. William Johnson**
Comoderator: **Ms. Selina Smith**
Panelists: **Mr. Henry Osborne,** *Director,* Community Services, WRC-TV, Washington, DC
Ms. Joyce Tobias, Parents Association to Neutralize Drug and Alcohol Abuse, Annandale, VA
Ms. Hannah Chambers, *Project Options,* Annapolis, MD
Ms. Reba Bullock, Maryland State Department of Education, Division of Instruction, Baltimore, MD
Dr. Denyce Ford, *Project Director,* Howard University Drug Education and Prevention Program, Washington, DC
Recorder: **Dr. Eleanora Isles**

Panel I
"Prevention Models for Black Youth at High Risk: Industry and Government"
Moderator: **Mr. Charles Avery**
Comoderator: **Ms. Artherine Rullow**
Panelists: **Dr. Alice Murray,** Kenilworth/Parkside Substance Abuse Prevention Project, Washington, DC
Dr. Terra Thomas, Human Resources Development Institute, Chicago, IL
Mr. Dennis I. Nordmoe, Bureau of Substance Abuse, Detroit Health Department, Detroit, MI
Mr. Peter Edwards, *Research Associate,* National Alliance of Business, Washington, DC
Recorder: **Mr. William Burrell**

Panel J
"Prevention Models for Black Youth at High Risk: Health Care and Civic Organizations"
Moderator: **Ms. Clemmie Saxton**
Comoderator: **Ms. Mitzi Rosemin-Pierre**
Panelists: **Dr. Wilbur Atwell,** Howard University Institute for Drug Abuse and Addiction, Washington, DC
Dr. Flavia Walton, *Director of Services to Youth,* The Links, Washington, DC
Dr. Bettina Scott, *Chief,* Clearinghouse and Network Development Branch, Division of Communication Programs, Office for Substance Abuse Prevention, Rockville, MD
Mrs. Marsha Zibalese-Crawford, *Project Director,* High-Risk Youth Prevention Project, Washington Area Council on Alcohol and Drug Abuse, Washington, DC
Recorder: **Dr. Kwamena Ocran**

Luncheon Plenary Session
"Primary Prevention from a Public Health Perspective: The Realities of the Urban Environment"
Convenor: **Dr. O. Jackson Cole,** *Dean,* School of Human Ecology
Introduction: **Dr. Lillian Holloman,** *Assistant Professor,* School of Human Ecology
Speaker: **Dr. Reed Tuckson,** *Commissioner,* DC Commission of Public Health, Strategy Sessions for Model Development, Strategy Group I
Moderator: **Dr. Allan Johnson**
Recorder: **Ms. Jean Mettam,** Strategy Group II
Moderator: **Dr. Barbara Nordquist**
Recorder: **Dr. Ouida Westney,** Strategy Group III
Moderator: **Dr. Robin Hailstorks**
Recorder: **Dr. Velma LaPoint,** Strategy Group IV
Moderator: **Dr. Wilbert Wilson**
Recorder: **Dr. Fatma Huffman**

Closing Address
"An Ecological Model for Prevention of Drug Use"
Dr. Cecile H. Edwards, *Professor of Nutrition,* School of Human Ecology, Howard University, Washington, DC

CHAPTER 1

Plenary Session Presentations

Implications of Alcohol and Other Drug Use for Black America

Beny J. Primm, M.D.

The World Health Organization defines substance abuse or drug dependence, as "the state produced by repeated administrations of drugs such that the drug user will engage in substantive and revocable behavior patterns over an extended period of time with such behavior leading specifically to further administrations of the drug." This definition is fairly general regarding alcohol and other drug (AOD) abuse, and one that is accepted throughout the world.

AOD abuse is a multifaceted problem—psychological, physiological, and, certainly, sociological. Thus, it must be approached from those perspectives because almost every one of those areas affects it in some way. Economics also affects AOD abuse; indeed, such abuse is affected by the state of the economy in this country and in the rest of the world because unemployment and other social conditions are related to it.

Among the psychological or physiological factors, stress is highly correlated with AOD problems. Stress is defined as "a nonspecific response of the body to any demand." That could be cold, heat, hunger, thirst, or almost any kind of problem the body may encounter.

According to the scale of stressful life events, the most stressful life events are the death of a child or a spouse, followed by the death of a mother or a father. Other stressful life events are marital separation, loss of a job, and even job promotion. Each life event is assigned a score on the stress scale; a total score of 100 or more makes a person a perfect candidate for alcohol and other drug problems.

The renowned physiologist Hans Selye has often said that some people are under constant stress. For example, for some people in certain neighborhoods, hunger, poverty, high unemployment, and poor housing always exist. Regardless of what these people do, their situation does not seem to change. Such stressful conditions certainly predispose them to AOD problems. Evidence of this interaction in the Black community can be clearly seen.

In a survey conducted by *USA Today*, participants were asked whether they knew someone or were close to someone who was chronically hungry. Twenty-five percent of whites responded in the affirmative, compared with 35 percent of Hispanics, 49 percent of Blacks, and 28 percent of all other races. It is noteworthy that such a large percentage of Blacks see or know people who are hungry, because there are many hungry people in Black neighborhoods and communities. By the same token, it is significant that most whites do *not* see many people who are hungry. Of course, this may be because there are far fewer hungry people in white neighborhoods and communities.

People working at minimum-wage jobs often exist under severe stress. The minimum wage, which has not changed since 1981, is not enough to support a family of two or three; even with the family member working a 40-hour week, that family still would be below the poverty line. Many Black, Hispanic, and Native American families in this country are especially affected by this stressful condition and thus are also vulnerable to AOD problems.

Then there is the issue of unemployment. During a recession, all races are affected and can become unemployed. However, when the recession is over and recovery comes about, Blacks and other minorities continue to be unemployed. Blacks still remain the last hired and the first fired. This situation, too, leads to chronic stress among Blacks.

As a group, women experience stress as a result of disparities in employment and earnings. Women's earnings amount to only 69 percent of men's earnings. Many Black women are heads of households, which in itself is a stressful condition. Thus, unable to earn the amount of money necessary to take care of their family responsibilities, many women—and many Black women in particular—turn to AOD.

In fact, there are many women in AOD treatment programs today. Compared with, say, 10 years ago, when women represented about 10 percent of the population in such treatment programs, in 1987 women represented about 40 percent of that population, or 4 of every 10 persons in AOD treatment programs. Ultimately, as women assume more responsibilities, an increasing number of them will suffer heart attacks and emotional stress as evidenced by ulcers and hypertensive cardiovascular disease. This situation will also mean an increase in their use and abuse of AOD.

Racial violence has also increased stress in Black communities. According to a 1978 report of the Department of Justice's Community Relations Service, there were only 8 cases that year; in 1986, however, there were 276, and in 1987, there were that many in just the first part of the year.

Wherever stress is rampant in cities, there will be many homicides. New York City has the greatest number of addicts as well as the greatest number of

homicides. Of course, Los Angeles, Chicago, and Detroit also have high homicide rates as well as a high incidence of AOD abuse. In addition, Detroit has a high suicide rate. Not so long ago, it was unheard of for a Black person to commit suicide. At present, however, particularly in cities all over this country, Blacks are committing suicide in greater numbers. This situation is certainly a result of stress.

In addition to all these factors that affect AOD abuse, some personality factors are common among drug users. These include impulsive behavior, difficulty in delaying gratification, and sensation seeking; a weak commitment to any rational value system; an antisocial personality, a sense of social alienation, and general tolerance to deviation; a sense of heightened stress; and a lack of self-esteem. People with these personality traits tend to vacillate between states of depression and anxiety. Physical and sexual abuse in childhood is common in their backgrounds, as are sharp conflicts between parental values and the values they may choose from their peer groups.

There are several kinds of drug users. The first type consists of those who may try various drugs once or twice out of curiosity. These users may then stop. The second type of drug users use drugs to get high with friends, to be sociable at a party, or to get into the mood of things. These users are close to becoming chronic drug users, particularly if they use drugs every weekend. The beginning use of cocaine in particular has caused many people to become dependent on cocaine, even if only on weekends. They wait impatiently for the weekend so they can get to the drug. Thus, compulsive behavior and the reinforcing pharmacological effects of cocaine make for a very dangerous combination.

Regular users are the third category of drug users. They use drugs constantly to achieve or maintain a desired state. In other words, they cannot go to work in the morning or get through the afternoon unless they smoke a joint. Such use is so common in New York City that if one goes down near Wall Street where people sit outside around the stock exchange to have lunch, one cannot get through the crowd without becoming aware of marijuana use in the area.

The fourth category of drug users consists of dependent users. These are people who cannot relate to anything but drugs, and they do nothing but practice drug-seeking behavior. They experience both mental and physical discomfort when they need drugs, and they will do anything to obtain drugs.

And there are other influences on drug abuse behavior, as well—namely, the mind-set, the setting, and the mood. The mind-set in which people take drugs is the attitude with which they approach the whole experience. The setting is the environment in which they take drugs. That environment generally is conducive to drug taking—for example, the lights are low or there is availability. The mood can be happy, angry, depressed, anxious, hyperactive, giddy, tranquil, disgusted, frustrated, or sexy. All these moods are enhanced by certain drugs.

Many people often do not limit themselves to one drug; instead, they mix drugs. For example, they might mix heroin and cocaine—called a speedball—or heroin and alcohol to achieve a certain High.

Given all these factors, it is not surprising that AOD use has become a number one priority in our Nation today. For one thing, such use has taken its toll in our schools. Many students, particularly Black high school students, use an enormous amount of drugs. At the same time, Black high school students are dropping out of school at rates disproportionately higher than the rates for students of other racial groups. According to the data, Black and Hispanic students who drop out of high school use drugs 67 percent more than do students who stay in high school. Because of the high incidence of drug use among Black students, it is remarkable that so many actually make it to their senior year, and even more remarkable that many of them graduate.

Smoking is also a form of drug use, and it should be considered in the same way as all other narcotics use because it is detrimental to health. Cigarette smoking is also on the rise among young people between the ages of 20 and 24. What is worse, all around this country, young Black women are smoking as early as 12 and 13 years of age. Many are almost chain-smokers. One reason for the increase in the use of cigarettes is that Black women and, indeed, the Black community have been targeted by advertising companies in various billboard and magazine campaigns. Numerous billboard ads have appeared in Black communities, and they do not say "drink orange juice for vitamin C." Instead, they advertise alcohol and cigarettes. This trend is also evident in many Black magazines and weeklies. This is done without consideration that the incidence of lung cancer among Blacks is much higher than it is among any other racial group and is actually the fourth biggest killer of Blacks in New York. In fact, lung cancer in Black women now has surpassed breast cancer and uterine cancer combined.

Smokers have a responsibility to nonsmokers—to avoid exposing them to cigarette smoke, particularly in the workplace. As a matter of fact, many employers are beginning to feel responsible for creating a drug-free, not just a smoke-free, work environment for those people who do not smoke. They have set aside rooms in the building for smokers to keep them away from nonsmokers while they are smoking. This action has, in effect, reduced smoking in the corporation as well as time lost from the corporation.

Alcohol abuse is also prevalent in our society today. People often say, "Well, I just have a glass of wine" or "I just have a can of beer" without realizing that such intake is equal to a shot of whiskey. Many people go through a 6-pack or even a 12-pack of beer during a football game, for example. Drinking a six-pack of beer is the same as drinking about a half of a fifth of distilled spirits. In this connection, people often pass out on city streets as a result of overconsumption

of alcohol. Many are often ignored by passers-by as is the serious nature of their disease. The community must begin to complain about this situation so that these people are aware of our concern and are directed toward treatment. Otherwise a message will be sent to young people that personal and public neglect of social problems is acceptable behavior. Cirrhosis of the liver, which is secondary to alcoholism, is much higher among Blacks than it is among any other racial group in this country. In New York, it is the second biggest killer of Black people.

Then there are the so-called "hard drugs." Among them, crack, a smokable form of cocaine, is readily available to schoolchildren for $5 and $10. In fact, crack is often confiscated right around school yards. This is a grave cause for alarm, given the detrimental effects of the drug. Crack gets to the brain in 8 to 10 seconds, sometimes less. It provides an intense, rapid high that lasts about 3 to 5 minutes before there is an intense crash. Thus, as soon as the high is over, the user wants to get high again. The reinforcement properties of the drug are so great that the user will do anything to get another high. There is intense craving, and, of course, the addiction is extremely rapid with severe medical and psychiatric consequences.

With regard to heroin and other drugs that are injected directly into the bloodstream, even worse problems can develop. Many addicts have open sores and scars on their chests and abdomens where they have subcutaneously injected drugs. Some addicts die from overdose before they can get the tourniquet off their arms because they have an anaphylactic reaction to the drug itself. Moreover, many impurities in the drug can cause immediate death.

A move is afoot to begin to issue clean needles among addicts to stop the spread of acquired immune deficiency syndrome (AIDS) or the human immunodeficiency virus (HIV). But clean syringes alone are not enough. All the other paraphernalia used in the ritual would also need to be issued to ensure their sterility. For example, there is the cooker into which the heroin or cocaine is put so it can be mixed with water, heated up into a solution, and be drawn into the syringe. Then there is the cotton ball used to filter out the lumps as the liquid drug is drawn into the syringe. So anyone who suggests that the use of clean syringes can stop the spread of the AIDS virus clearly does not understand the whole ritual of drug taking. Indeed, sterile needles may become contaminated by other exposure.

Moreover, in their craving for the drug, addicts do not take time to clean the syringe after use by another person. So even if the AIDS virus or any other could be killed by rinsing the syringe with bleach, addicts do not take time to do that. In fact, all the drugs that two or more users may have might be in one syringe, which they share with each other.

What can be done about the problem of AIDS transmission from drug needles? A social policy model of prevention ought to be established based on functional cultural norms and standards with morals and mores that are properly communicated to the public.

We may never be able to stop AOD problems in our communities completely, but we ought to be able to curtail it so that people can remain functional. This should be done with care, love, and concern by families, friends, employers, schools, and the courts.

Most major corporations in the Nation now have an employee assistance program (EAP). About 99 percent of the employees who go to the EAP go there for AOD problems. As was mentioned above, a variety of problems predispose people to AOD problem behavior. So, AOD abuse is probably underreported, particularly the kind that goes on in industry.

Intensive efforts must especially be made to help reduce AOD problems among youth. This can be done by developing skills and knowledge essential for day-to-day living. The following areas need immediate attention: the development of clear values, emotional coping skills, decision-making skills, communication skills, and alternatives to the use of AOD. It is vital that we teach young people how to handle stress so that their stress does not turn into distress for which they then seek a chemical to help to allay the feeling.

Several intervention techniques are useful when working with AOD addicts. First, it is important to be clear and factual when confronting users. Next, rapport must be established and serious concern must be shown for their addiction as a chronic disease. Furthermore, it must be recognized that people cannot stop using drugs immediately because the whole homeostasis of the body has changed, and their bodies long for the drug. People caring for AOD abusers must offer them hope but must be prepared for reactions of denial and anger. Caregivers cannot back down or argue with denial or rationalization. The helpers must not be reproachful, induce guilt, or predict disaster to add to the addicts' fear. Nor should helpers invite a confession or expect addicts to write one because addicts are not going to do so. Instead, helpers must be firm and insist that addicts change their behavior.

Reverend Obadiah Dempsey of New York became so disgusted with drugs being sold in the Harlem neighborhood where his church was that he put out a warning that read in part: "You can't sell drugs in this neighborhood" and "We're going to run you out." As one of the leading fighters against drug use in our communities, he tried to establish some social competency skills among the people he saw in his parish as well as among others in the street. He went into the street constantly sharing information with people about what they could do to help themselves out of addiction, poverty, illiteracy, and general apathy.

Reverend Dempsey developed this strategy out of frustration with the system. He did a wonderful job until his death about 5 years ago.

Other advocates, such as Edgar Adams, Ted Baptiste, and this writer, are fighting the war on drugs but we seem to be running out of ammunition.

Recommendations

The Black community needs to take a more proactive stance in fighting drugs in its neighborhoods. For example, in many instances, drop sites for drugs are located in inner cities, often near drug treatment programs. The community must band together to have these drop sites closed. In the same vein, there must be a move to help famous Black role models (athletes, movie stars) understand that the types of commercial advertising they do have a tremendous impact on Black youth. If they truly understood the severity of this problem and the great influence they have on youngsters, perhaps they would stop participating in alcohol and cigarette advertisements.

There are other positive steps the community can take. First, families must instill values in their children. Then the community must send out clear messages about what it will and will not tolerate. Because alcohol and tobacco are legal drugs, certain limits must now be imposed. Alcohol abuse must be treated seriously and legal steps taken to prevent or arrest such abuse for the public good.

More businesses and organizations need to get involved in the antismoking campaign. Smoking should not be allowed in open work areas; instead, there should be designated smoking areas for employees who smoke. Similarly, all restaurants and other public places should make this separation mandatory. Such action will eventually have the effect of reducing smoking.

Churches in the community must become more actively involved in preventing AOD use, particularly among youngsters. Recreation centers must be developed with a variety of activities for youth, including tutorial and computer programs. Furthermore, more churches must develop a human services component. For example, they need to offer family services, particularly for families on the brink of disruption. Schools, colleges, and universities also must become involved. After-school programs and extracurricular activities can be offered for neighborhood children to keep them busy and to help develop their values and self-esteem.

In summary, then, there must be involvement at all levels in the Black community to help alleviate AOD use problems. We need innovation, initiative, and positive role models for Black youngsters. They need successful experiences, and they need to see that they can achieve. They also need positive

reinforcement. If Black youngsters develop positive self-esteem, they are unlikely to be interested in drugs. This is the challenge to the Black community.

The Second Cocaine Epidemic

David F. Musto, M.D.

A nation that forgets about a catastrophic encounter with cocaine may be victimized again. The United States today, with an eager desire for cocaine echoing the cocaine craze of 80 years ago, offers painful proof of that statement.

Painful lessons last the longest, but a national memory often has only the lifespan of those who learn the lessons by living through the experience, which is not always bad. Patterns of prejudice and discrimination may begin to fade as new generations arrive and the older depart. Thus, fading memories can be helpful. But the natural result of fading memories can be seen also as new generations take for granted the hard-fought gains of their elders. And this situation can be irritating, at least to the elders.

Some events are so important to a nation or group that they fight desperately to keep the memory alive for later generations. The American War for Independence, the slave experience, and the Holocaust of World War II are examples; these are memories that give enduring meaning to later generations, and their loss would threaten a core of precious identity. But the battle to keep memory green is tough, even for the most meritorious or momentous past event.

There is another category of public memory, one that does not enjoy the benefits of the significant events I have just mentioned. These are negative episodes, which are forgotten with relief, like a rock in your shoe. What about the influenza epidemic of 1918–1919, which killed more than a half million Americans, a number larger than the number of American combatants killed in both World Wars? A forgotten misery. What about the terror of tuberculosis, at one time the leading cause of death in the United States? Gone with the spittoon. What about the introduction of cocaine to the public without restriction in the 1880s, the widespread use of the stimulant by the turn of the century, followed by a powerful public repression of cocaine, which was so successful that its significant use faded away? Also forgotten, and this is our common misfortune.

Whom shall we blame for this memory loss, which has made our Nation vulnerable to a second onslaught of that most seductive drug? I am afraid we must ascribe responsibility not to the Government, or to schools, or to law enforcement, but to ourselves. Being just human, we recall and act on what we have learned directly and intensively, less upon well-meaning or even accurate advice. And being human, we have brains that respond with intense euphoria to a chemical formed in the leaf of the coca bush. Perhaps our brains could have been formed differently to no one's disadvantage, but it did not happen that way. The result is that our encounters with cocaine are intense and initially appear totally good for us; only after extensive and lengthy use in our society are they

revealed to be extraordinarily damaging to individuals, families, and communities. Cocaine in society is like the infection of a virus that circulates apparently without harm for a while, then victims begin to appear in growing numbers.

The battle against cocaine ended victoriously around the time of World War I, and demand for the chemical remained low for decades. By the 1950s we had no cocaine problem in the United States, and furthermore, we had not had one for quite a while. No national campaign was being waged to warn children about cocaine for there was apparently no cocaine about which to warn them. The motion picture industry, with Government approval, maintained a policy of forbidding the presentation of drug addiction in films. *The Man with the Golden Arm*, relea ed in 1956, was the first major motion picture since the mid-1930s to show the use of an addictive drug—in this case, heroin. Cocaine's past—the decades-long battle against it early in the century—faded, for the new generations coming along had neither seen nor heard about cocaine. Our society was losing its "acquired immunity" against addiction to this drug, and we became as vulnerable to cocaine's deceptive lure as we would be susceptible to diphtheria without antibodies to it.

Still, does history so neatly repeat itself? Our times are different from those of a hundred years ago, and for the most part, we do not want to exchange them. The way our Government operates—or does not operate, for that matter—is different. I do not claim here that history must repeat itself in some inevitable or identical way. Perhaps we will not win another victory over cocaine. But this exposure of the American people a second time to the same seductive drug and the obvious similarities in cocaine's effect on our society then and now call out for study and comment. I would like to sketch briefly the first cocaine epidemic and then raise some questions for discussion with special relevance to the Black community.

Plentiful supplies of cocaine did not become commercially available until just over a hundred years ago. Then pharmaceutical manufacturers produced cocaine in large amounts and advertised and distributed the product internationally. In some countries cocaine automatically fell under the provisions of pharmacy laws, which limited access to the drug. The United States, however, had no national drug law. Nor did the States have any effective controls. For all practical purposes, cocaine could be sold in any amount to anyone. Think of that—easy availability of an intensely euphoric drug that initially appeared to have many good and no bad effects.

One reason for this ready access in the United States was the separation of powers in the Constitution. The States held the police power that regulated drugs and the practice of physicians. But they had irregular and ineffective laws on drugs and no control over drugs brought across State lines. The Federal

Government, however, could tax or control interstate commerce but did nothing to invoke these Federal powers to control or prohibit opiates and cocaine. For cocaine, America was the land of opportunity.

Just before purified cocaine became easily available, one could detect a growing enthusiasm about coca leaves and the alcoholic extract. In 1877, a year after the Nation's centennial, good news appeared in the pages of the solemn *Boston Medical and Surgical Journal,* which is now known as the solemn *New England Journal of Medicine.* Dr. Archie Stockwell had been experimenting with coca. In moderate doses, extract of coca leaves had effects that marked it as one of the most remarkable drugs ever known to the medical profession. Dr. Stockwell announced that "coca ... diminishes weariness, strengthens the pulse, calms nervous excitement ... and increases mental activity," and he concluded, "Careful observations lead me to believe that, so far from being injurious, the moderate consumption of coca is not only wholesome, but frequently beneficial."

Dr. Stockwell's attitude illustrates a common reaction to a new drug: the good or potential good is proclaimed; danger is minimized. Physicians are as susceptible as anyone else to the pleasure of surprising others with good news. Caution is a downer, or at least it seldom makes the headlines. Less than a decade after Dr. Stockwell's encouraging news, purified cocaine arrived on the market. If extract of coca leaves was good news, cocaine was great news. Here is what one of the major American manufacturers had to say about cocaine in 1885:

> [Cocaine] can supply the place of food, make the coward brave, the silent eloquent, free the victims of the alcohol and opium habits from their bondage, and as an anesthetic, render the sufferer insensitive to pain, and make attainable to the surgeon heights ... never reached before.

Too good to be true? Yes, but what I am describing is not just a manufacturer's attempt to sell a product. I am confident that Dr. Stockwell did not intend to lure patients and colleagues into bondage to cocaine. The evidence reflects the uncritical first stage of a drug's entry to the market. One of our human weaknesses is to see what we want to see, and to avoid or even deny reality that conflicts with our outlook. With a chemical like cocaine, which creates euphoria on its own, the first stage is especially uncritical.

How did Americans respond to this drug? Parke-Davis gave this estimate:

> Today [1885] there is not a second-rate drug store in any one of our cities which does not keep on hand a small supply of [cocaine], and manufacturers have been obliged again and again to increase their capacity to produce it, so active has been the demand.

Parke-Davis displayed creativity in the ways in which it provided cocaine. You could buy fluid extract of coca, wine of coca, coca cordial, coca cheroots, coca cigarettes, cocaine inhalant, cocaine salve, cocaine for injection, and just plain cocaine. Athletes bought it to boost their skills; hay fever sufferers sniffed it to shrink their nasal and sinus tissues. Some employers were said to discover that cocaine got more work out of employees, especially those doing hard work, while it cheered them.

We have all heard how Sigmund Freud popularized cocaine in Europe beginning in 1884. He saw it as a remarkable drug for serious ailments as well as everyday difficulties. But the United States had its own cocaine champion, one so prominent, in fact, that when Dr. Freud got into some difficulties over his claims for cocaine, he invoked the American drug expert as a defense for himself and the drug. I am referring to Dr. William A. Hammond, a former Surgeon General of the Army and prominent professor of neurology at a New York medical school, who eventually moved to the District of Columbia where he operated a sanitarium featuring injections of animal extracts. Dr. Hammond found in cocaine a marvelous drug. He defended it for years against critics who said it was addictive and dangerous.

Why this unclouded enthusiasm for a new drug? I do not believe Dr. Hammond's boosterism was just a way to sell more of his cocaine wine. A new drug does not occur in a vacuum. A new drug appears in a medical profession striving against the frustration of therapies of which even the best have drawbacks. A new drug appears in a society frustrated by the difficulties of living—sorrow, illness, disappointment, and lack of confidence. As a drug that initially produces confidence or cheerfulness, cocaine is particularly likely to fulfill our fantasy about an ideal stimulant. What is wrong with feeling good, as Dr. Hammond might have said.

The second problem about new drugs is that complications may not arise until the drug has been used for a time. The complications may be terrible, but if the rate is, say, one in a hundred every month, the casualties will seem negligible until the drug is used widely for several years. As fear of the drug grows over time, the awful effects become more and more prominent, and drug experts, even the most optimistic ones, are less likely to defend the "harmlessness" of the drug.

During the 1890s cocaine use spread throughout American society. It was presented as a headache remedy, a treatment for hay fever, a cure for alcoholism and opium and morphine habits, and a general tonic. Beverages containing cocaine proliferated. The amount of cocaine in Coca-Cola until its withdrawal about 1903 was modest, but here are some slogans Coca-Cola used during its cocaine phase:

"The wonderful nerve and brain tonic and remarkable therapeutic agent."

"For headache and exhaustion, drink Coca-Cola."

"Coca-Cola makes flow of thought more easy and reasoning power more vigorous."

"The ideal brain tonic."

Coca-Cola had many competitors who have since fallen by the way. In 1909 the Agriculture Department listed soft drinks that contained extract of coca leaves. These included Cafe Cola, Coca Beta, Rocco Cola, Cola Coke, Koca Nola, Kola Kola, Mellow Nip, Wise Ola, and one manufactured by the Rainbow Bottling Company of Atlanta that seemed to say it all: Dope. Most of these coca leaf drinks were manufactured in the South, a circumstance that helped link cocaine use with the Black community in the minds of some new drug experts and of whites fearful of Black hostility.

Cocaine's image began to tarnish in the 1890s, about a decade after its astounding appearance. Except for its limited medical uses as an anesthetic, cocaine was now without eminent defenders. By World War I its image had changed from the ideal tonic to the most hated and feared drug in America—a remarkable reversal within 20 to 30 years.

As cocaine's reputation switched from positive to negative, white legislators, drug experts, and writers began to associate it with the Black community, especially the Black community in the South where, of course, the vast majority of Blacks lived at the turn of the century. Several reasons account for this linkage but let me preface them by noting the extent to which cocaine had been recognized as a national problem.

A commission appointed by President Theodore Roosevelt described cocaine as out of control in the District of Columbia. A Government official reported that cocaine "in most instances wrecks the individual and all depending on him, as well as jeopardizes the lives of many." The United States began an effort to control opium and cocaine at the international level. Following the first international meeting on narcotics in 1909, the official report to Congress included many references to the cocaine problem in the United States and urged Federal action. Congress was told that "the cocaine vice [is] the most serious that has to be dealt with [and] has proved to be a creator of criminals and unusual forms of violence."

We are now close to one of the factors that linked Blacks and cocaine: the call for Federal action. Here is a crucial passage from that report to Congress by then President Taft: "The misuse of cocaine is undoubtedly an American habit, the most threatening of the drug habits that has ever appeared in this country. ..." The year was 1910, one life time ago.

But at this time Federal action against problems such as drug use was severely limited by the strict separation of Federal from States' rights as noted previously. Furthermore, Southern Senators and Representatives were the staunchest defenders of States' rights. In trying to overcome Southern congressional opposition to an infringement of States' rights then, the Federal executive emphasized the use of cocaine by Blacks. The *New York Tribune* quoted a prominent white Atlantan in 1903 to the effect that "many of the horrible crimes committed in the Southern States by the colored people can be traced directly to the cocaine habit." The *New York Times* in 1914 quoted a leading drug expert regarding the "Negro cocaine fiends" who terrorized the South. Furthermore, cocaine was said to improve a shooter's aim, unlike alcohol, which was assumed to make aim worse. Cocaine somehow gave such strength to the user that police departments had to get larger caliber guns. These reactions to cocaine can be multiplied. The linkage of a feared minority with a specific drug is not unusual. Here we had an association based on one of the most dreaded aspects of cocaine: violence.

I believe there was no greater use of cocaine by Blacks than by whites in the South. In fact, there is some evidence that Blacks used it less, but for our understanding of links between cocaine and the Black community, it is enough to point out that this link was asserted around the time of World War I with little opposing argument. For some Southern whites the claim helped justify their repression of Southern Blacks, and for the Northern whites, the claim helped calm Southern legislators' fears of States' rights violations if the Federal Government acted against cocaine.

The rising fear of cocaine in all parts of society led to Federal laws that first required labeling of cocaine content on over-the-counter remedies and then gave rise to even stronger Federal and State laws against cocaine. Along with these laws and increasing public fear of the drug was a decline in cocaine's use to an extremely low level. Eventually, though, the memory of the first cocaine epidemic faded. Many Americans believe that we are now experiencing a catastrophic contact with cocaine for the first time.

What can we say about cocaine's associations today? The drug problem in America has always been subject to oversimplification, especially when we enter a crisis of fear and anger at drugs or a time when drugs seem the miraculous answer to all our personal or social problems. When we turn against drugs and become intolerant of their use and often of their users, that attitude is reflected in other aspects of our approach to living. This is what we might expect if we look at a problem ecologically—everything is connected. The error would be to think we can react to the danger in drugs without undergoing a broader change in our feelings about what is good and bad in our environment. A more critical attitude toward drugs does have good effects but we also have seen how the

widely believed but false link between Blacks and cocaine snapped together as cocaine became the most feared drug in America before World War I.

Fear of cocaine stimulated and was part of a broader change in attitude earlier in this century. There were many targets, not just cocaine. Alcohol was a major target because it created inefficiency in the workplace, damaged the babies of mothers who drank it, and led to violence in the family. Countermeasures included exercise and healthy food. This is when yogurt appeared on our food horizon. Concern about misleading advertising of over-the-counter remedies led to the Pure Food and Drug Act of 1906. Alarm over the destruction of forests and pollution of streams led to other remedies. The very word *ecology* was employed for this connectedness. This kind of a movement—learning to deal broadly with everything we take in, whether drugs or smog—leads to both fighting illness and promoting health. A shift from tolerating drugs to being intolerant of them and of other things as well.

No big social movement like this is without its dangers. Some lessons from the past are encouraging, but some are worrisome. If we can avoid scapegoating the Black community, there is still the problem of cocaine. The first cocaine epidemic suggests that the demand for cocaine can be reduced within a community as that community becomes alarmed by the actual effects of cocaine. The drug problem has many aspects—foreign supply, transport to this country, distribution, and, finally, the users who buy the product. The lessons of the first epidemic are that it can be ended, it is not hopeless, and a battle fought over cocaine may carry on to other drugs that ultimately bring neither happiness nor comfort, but weakness and community disorganization.

Prevention Models Targeted to Black Youth at High Risk for Alcohol and Other Drug Problems

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My focus is on prevention models targeted at high-risk youth in critical social, educational, and public interest areas. Thus, I will discuss and review some issues surrounding the abuse of alcohol and other drugs (AOD) among high-risk populations, talk about Federal efforts to prevent AOD problems, and present some non-Federal strategies that could also be used to prevent AOD problems in Black communities and among high-risk youth.

Overall, 72.4 million Americans over the age of 12, or 37 percent of the population, had tried marijuana, cocaine, or other illicit drugs at least once in their life time (NIDA Household Survey). Every day, on average, 5,000 people try cocaine for the first time. Furthermore, 18 million Americans have problems with alcohol, and of these, 4.6 million are teenagers (1985–86 Summary of Secretary's Task Force on Black and Minority Health (Volumes on Chemical Dependency and Diabetes)). The United States continues to suffer the highest rates of teenage and young adult substance abuse in the industrialized world (William Bennett, "Children and Drugs," *Education Magazine*, Winter 1987).

In minority communities, where many high-risk youth live, AOD use may actually be commonplace. These communities are often plagued by marijuana, heroin, and cocaine abuse, with drug dealers openly operating on the street corners of our inner cities.

Alcohol misuse is a factor in more than 10 percent of all deaths in America. Furthermore, about one-half of all homicides in this country are related to the use of alcohol, while illegal drug use is involved in 10 percent of all homicides. In some of America's largest cities the figure is even more alarming: More than 20 percent of homicides are drug related.

During my 25 years of involvement with community mental health, I directed the Area D Community Health Center, which is on the grounds of St. Elizabeth's Hospital and which is now a part of the District of Columbia's comprehensive mental health system. We had a very active and, I would like to think, very effective AOD prevention program. I have also witnessed firsthand the damage that AOD can do to young people, minorities, and whole communities. For this reason I am going to talk about AOD problems and programs as they relate to Black people as well as to high-risk youth.

As we all know, Blacks are seriously afflicted by alcohol and other drug problems. AOD abuse is a major cause of the health disparity that exists between Black and white Americans. Our most recent data tell us that 31 percent of the individuals reporting to emergency rooms with AOD-related problems are Black. The drugs with which Blacks are most frequently mentioned as being involved are heroin and morphine, 24 percent; cocaine, 20 percent; alcohol in combination with other drugs, 18 percent; and PCP alone and in combination with other drugs, 10 percent. Blacks account for 35 percent of all cocaine-related deaths and 57 percent of all PCP-related deaths.

In addition to the usual kinds of health problems associated with excessive alcohol use, we seem to be particularly at risk for cancer, severe malnutrition, hypertension, and birth defects. Cirrhosis was the ninth leading cause of death in America in 1984, and mortality rates from cirrhosis among Black Americans remain unusually high, nearly twice as high as among whites. This situation is despite the fact that the mortality rates from cirrhosis in the general population have been steadily declining since 1983. According to the *Sixth Special Report to Congress on Alcohol and Health,* issued by the Secretary of Health in January 1987, these rates for Black adults are 20 per 100,000 deaths, as compared with 11 per 100,000 deaths for white adults.

In addition, the Federal Government estimates that 5.7 million women are alcoholics or alcohol abusers. We know that alcohol consumption during pregnancy increases the risks of birth defects and of low birth weight, and it may lead to Fetal Alcohol Syndrome. This factor is significant in infant mortality, which in itself is a serious health concern among Blacks. Recent evidence indicates that the risk of alcohol-related birth defects is higher for Black women than it is for either white or Hispanic women. This higher risk appears to be independent of other variables such as smoking or socioeconomic status.

For Black families and Black communities, then, AOD abuse is an insidious enemy that compromises the health and well-being of the people and the social and economic viability of the community. Within our Black families, AOD abuse contributes to anger and intimidation, physical abuse, emotional turmoil, child neglect, and fragmentation. Within the Black community, it operates as a powerful negative dynamic to lower the quality of life, not only for AOD abusers themselves but also for their families, neighbors, and coworkers. It also exacts a heavy toll on our communities in the form of increased crime and delinquency, poor school and learning environments, and higher costs for health care. Alcoholism and alcohol abuse cost our society an estimated $117 billion in 1983. This cost includes lost jobs and impaired productivity in the workplace, health care costs for treatment of alcohol-related health problems, motor vehicle crashes, and violent crimes. We do not know how much of this cost was borne by Black communities. However, when we consider the findings of the DHHS Task Force on Black and Minority Health, which showed that alcohol-related

problems are among the chief causes of illnesses and death among this Nation's minority population, it is likely that Black communities paid dearly, not in dollars but in even greater terms—human lives.

The way we view alcoholism has changed over the past few years. In some communities, the use of alcohol, even in excess, has had an air of sociability and acceptance. Kids in the 1960s used the drinking of their parents as an excuse to get high on pot and other drugs. When challenged, they had a good counterargument: "You drink booze and you smoke cigarettes. So what's the difference?" Those of us who were honest with ourselves stopped to think, and we realized that the kids had a point.

Historically, any problem with alcohol was viewed by society in general as a moral problem rather than a health problem. As our knowledge has increased about the biological and psychological factors that contribute to alcohol problems, however, we have come to realize that alcohol abuse is a major health problem and not simply a problem caused by an individual's moral weakness or lack of character. But even though people may publicly voice their understanding of alcohol abuse as a health concern, there remains a private, stronger belief that nice people do not have trouble with alcohol. Because of this underlying belief, those who do have problems with alcohol remain stigmatized. The stigma hampers efforts to intervene; what is more important, it results in public reluctance to acknowledge alcohol abuse and alcoholism as a significant public health threat.

Many people who work in alcohol prevention and treatment programs in Black communities have voiced concern that the stigma attached to alcohol-related problems may be even greater within the Black community than it is within the white community. This view has repercussions in terms of funding for prevention and treatment efforts. It also weakens the public's commitment to help those caught in the alcohol trap or at risk of becoming involved.

Public awareness about AOD abuse issues is now at an all-time high but we cannot afford to relax in our determination to speak out about these issues whenever we can. By participation in conferences such as the Human Ecology Forum, and through educational and advocacy efforts, we can help to ensure that the Black community receives its fair share of resources and programs for preventing and treating alcohol and other drug problems.

Traditionally, our Black communities have lacked the necessary resources to mount an effective campaign against AOD problems. There is a Federal effort, however, that we believe will help organizations and community groups pursue their AOD prevention programs more effectively.

Federal spending for AOD abuse programs has more than tripled since 1981 to nearly $4 billion in 1987. This budget includes enforcement of drug laws,

treatment of AOD addiction, prevention education, drug screening in the military, eradication of illegal drug crops, and many other related activities. The Anti-Drug Abuse Act of 1986 provided sweeping authorizations for dealing with AOD problems in America. The allocation by this legislation for combined law enforcement and prevention activities was $1.7 billion. The act also created the Office for Substance Abuse Protection (OSAP) to carry out activities to reduce demand and prevent abuse. OSAP is located within the office of the administrator of the Alcohol, Drug Abuse, and Mental Health Administration, a component of the Public Health Service. Congress also allocated $41.5 million to support OSAP's demonstration grants, communications, and community assistance programs during fiscal year 1987. Of this, $24 million was earmarked for a demonstration grants program targeted at high-risk youth.

Who are these kids we call high-risk youth? Everyone acknowledges that they exist. Estimates put their number at well over 10 percent of our overall youth population. However, they account for a larger proportion of all the crime and drug use among young people. These kids usually have interrelated problems. They may be school dropouts. They may be involved in serious juvenile crime. They may be economically disadvantaged. They may be latchkey children. They may be victims of various forms of physical or emotional abuse, or they may be physically disabled. Many live in homes in which parents abuse alcohol and/or other drugs. Usually more than one of these factors is involved. These are the multiproblem kids in our society, the ones who seem beyond help and immune to intervention (Public Law 99-570 & H.R. 5582 correcting P.L. 99-570 Oct. 27, 1986). But these young people are exactly the ones toward whom our attention must be directed. These children and adolescents that we call high-risk youth already have enough problems. They are particularly susceptible to involvement with AOD, and they are the least equipped to resist them. They desperately need our help.

The following passage from a new booklet titled *How It Feels To Be Chemically Dependent* touched me deeply:

> To be chemically dependent is to build walls around yourself, high, thick, impassable walls which keep your feelings trapped inside. To be chemically dependent is to live in self-imposed isolation. It is to feel unwanted, uncared for, and unappreciated. It is to live on the fringes, and never fit in anywhere. It is to feel a terrible loneliness in the pit of your being that no amount of alcohol or other drugs can ever appease. ("How It Feels To Be Chemically Dependent," Evelyn Leite, Johnson Institute, Inc., Copyright 1987. Edited by Pamela Espeland)

That moving passage describes a terrible existence, one that we do not want for our young people.

We at OSAP are determined to help prevent the despair that is caused by AOD abuse. To do this, we must begin at the beginning with the children. Earlier this month, OSAP awarded 131 high-risk youth demonstration grants to various public and private sector nonprofit groups around the country. These grants will support the development and evaluation of community-based prevention programs to reach those young people at greatest risk for AOD problems. This target population encompasses 4 million young people who live in public housing, including many Black people and a large Native American population. A number of those grants were awarded in Washington, DC.

Just to give an idea of what we were up against, we sent out award announcements, in the form of invitations to a party, thinking that nobody was going to come. Instead, we got 981 responses to our invitation. We had a non-Federal review panel that deemed 291 of those applications eligible for funding via the predetermined criteria. We had enough money to fund 131 of those 291. The point in all this is that we have the know-how—at least through those 981 grant applications—to develop some strategies and prevention models to try in our communities. It is the funding resources that are simply not there. They were not there for us to respond to even those 291 that met the criteria, and that is not to say that the other applications were not worthy of consideration. So we have a long way to go to meet the needs. Of the grants, 51 percent were directed to urban and inner-city youth, about 22 percent were targeted to Blacks alone, and an additional 6 percent went to Blacks and Hispanics. These grants represent more than $6 million in funding out of $24 million for programs that will reach Black communities.

We are excited about this grants program, and we will be watching it closely over the next year or so to identify techniques and programs that can be used in other communities. We anticipate that these demonstration grants will result in new and innovative ways to reach and help this country's most vulnerable group of young people. OSAP's Division of Community Prevention and Training is providing conference support and technical assistance to many fine organizations across the country to help ensure that the latest prevention information and activities reach into communities where they can do the most good.

In addition to our grants and community assistance programs, OSAP has a very active and productive communications program. We have established the National Clearinghouse for Alcohol and Drug Information, with Dr. Bettina Scott as its director. The Clearinghouse is a national resource of print and audiovisual materials and data base support on all aspects of AOD information. Special target groups include community leaders; persons working with youth, parents, and health and human service providers; and persons with AOD-related problems. We are developing AOD literature, documentary films, and public service announcements for television and radio, and we are working

closely with many public health and private sector groups to make these materials as accurate, timely, and as helpful as possible.

OSAP's prevention efforts are focused primarily on young people, the key to America's future, and it is with these young people that we have the greatest chance of success. We must convince them that AODs are not a necessary part of their lives. Each of OSAP's programs is designed to accomplish this goal. Through our demonstration grants program, we hope to identify prevention strategies that work and that can be used successfully in other communities across the Nation. Our community assistance program is helping groups with their prevention workshops and conferences. Our communications program is providing educational and informational material to increase public understanding and awareness of AOD issues.

Although we have high hopes for these programs, by themselves they are not enough. Earlier I said that alcoholism and alcohol abuse cost our society an estimated $117 billion in 1983. The Federal Government's $4 billion allocation in 1987 to conduct both AOD prevention programs is, by comparison, a drop in the bucket. Obviously it will take a partnership formed among the Federal Government, State and local governments, private sector businesses, organizations, and community groups to address this problem adequately.

In addition to OSAP's programs, there are many other initiatives that must be pursued at the State and local levels, in the private sector, in communities, and among groups. Several are basic initiatives that we all recognize as vital to overcoming AOD problems among young people and minorities. These include culturally sensitive educational campaigns that are specifically designed to increase awareness about AOD in Black communities; the involvement of professional and lay members of the community in disseminating AOD use information and advocating prevention; the formation of community support networks that include schools, clubs, churches, and prevention activities; more health care and related personnel who are specifically trained to work with chemically dependent people; and finally, more reliable data on the incidence of AOD use among minorities and high-risk youth.

Because specific data on the use of AOD among Black people are very limited, we must use related mortality statistics and data from treatment centers, emergency rooms, and medical examiners to assess the AOD problems in our communities. This limited information tells us that AODs are a significant problem among Blacks, but the lack of specific data hampers efforts to acquire additional services and properly allocate resources. The problem of insufficient data also applies to high-risk youth. Because what we know about AOD use among young people is derived from broad, general population surveys, data on high-risk youth are usually very limited or missing entirely. The annual high school senior survey provides us with the most comprehensive cross-sectional

data on young people and drugs; however, high-risk youth are seldom high school seniors. Once again, we need better data.

Within our Black communities, many health services are inadequate. Low income and lack of health insurance coverage are formidable barriers to seeking health care, including treatment for AOD problems. Obviously, high-risk youth are also underserved in health care. Workplace initiatives and school-based clinics can help bridge the gap between need and availability. In addition, several States have instituted programs to address this deficiency. Rhode Island, for example, has mandated health coverage for chemical dependency, and New Jersey has instituted a coupon program for treatment. Maryland is currently considering a plan for comprehensive drug prevention to be provided through localities.

Private sector organizations also have an important role. They must be encouraged to sponsor the training of Black physicians, nurses, counselors, and other health care providers who could have a very positive impact on alcohol and other drug abuse patterns in our Black communities. Incentives must be offered to ensure their recruitment and retention in the community. In addition, Black health care professionals, especially males, are urgently needed to serve as role models.

From a prevention standpoint, it is important that we, as professionals and as parents, provide our young people with the right messages and the right environment to discourage AOD use. We must be firm in projecting a nonuse message. Our children and teenagers must understand that AOD will not be tolerated. Kids who have been turned off AOD can become powerful and effective advocates of the nonuse message as they turn peer pressure into a positive force for preventing AOD use. It is equally important that we provide our young people with protective environments that will allow them to grow into healthy, mature, responsible adults. This protective environment must extend beyond the family into schools, churches, scout groups, and housing projects. It must extend throughout the community to promote a healthy, safe, and meaningful lifestyle for all our young people. Entire communities can set goals, identify objectives, and make commitments toward becoming drug free. For example, the Black community in Cherry Hill in Baltimore, MD, closed ranks and successfully fought to keep liquor stores out of their neighborhoods for many years. Although their action was based heavily on moral grounds, it undoubtedly had much to do with the destructive nature of alcoholism and alcohol abuse on the home, the family, and the community as a whole.

Networking activities among State and local government agencies and concerned groups in the private sector are crucial to the success of any AOD prevention program. Concerned individuals must come together to share information and formulate model programs for dealing with AOD use among high-

risk youth. Aside from attending conferences, such individuals can also serve as one-person public information programs to spread the word among colleagues, neighbors, and families about the seriousness of AOD-related problems for Black Americans and for all young people. They can also seek out others who can pass along the word.

These activities can happen within traditional organizations in our community such as schools, churches, and social and health care agencies. It can also happen among individuals or organizations who interact daily with members of the community, such as grocers, barbers, beauticians, and community social clubs. Although these are not ordinary sources of public health information and education, they do have an open conduit to individual community members.

In addition, concerned persons can also let their community know what other communities are doing to reduce and prevent AOD problems. For example, a number of communities are concerned because Blacks seem to be among those groups targeted by alcoholic beverage producers in their marketing strategies. They are also bothered by what appears to be a disproportionate number of alcoholic beverage sales outlets located in neighborhoods with large numbers of Black residents. Other communities are working to prevent high-risk behavior in Black youth, including the use of AODs. Further information on these issues is available through OSAP's Clearinghouse and from many other organizations working in the alcohol and other drug field.

In closing, I would like to offer concerned individuals a threefold challenge: first, become even more involved in alcohol and other drug use prevention in your communities; second, further extend your links with other groups, organizations, and individuals to exchange information and ideas and enhance available resources; and third, become an advocate for more prevention and treatment resources, improved programs, and better access to health care for young people within Black communities. We can all provide even greater insight into AOD use among high-risk youth if we work together. In the past these young people have either been ignored or allowed to fall through the cracks. We cannot allow this to happen any longer.

OSAP stands ready to do all we can to help in the commitment to overcome AOD use among our country's young people. We want to form a partnership with State and local government agencies, with national organizations, and with other groups that are concerned about AOD use. Working together in conferences and as active members in groups and organizations, we can raise a strong collective voice for improved prevention and treatment programs and for better access to health care for Black Americans and for our high-risk youth, whatever their color or ethnic origin. Working together we can make a difference. Our voices will be heard in communities, in government policy and planning offices,

and in the legislatures of this Nation. Our hope is that we will soon achieve our goal of drug-free communities, drug-free young people, and a drug-free America.

[At the conclusion of Ms. Smith's presentation, a District of Columbia youth addressed the session.]

I would like to share my experience, strength, and hope about my drug problem.

First, I would like to share my experiences. It does not matter what color you are or what race you are; it does not matter; drugs do not discriminate. I "used" to live, and I lived to "use." I went to any lengths to get a drug. Drugs carried me to places such as jail and St. Elizabeth's. I have been mentally dead, mentally handicapped, and emotionally whipped. And the only source of strength that I found through all of my problems was God.

You see, when I was inside that institution at Oak Hill, I was trapped inside of myself. Then I dropped to my knees, I surrendered, and I asked for help. And that night when I prayed, that door opened, and I ended up in St. Elizabeth's Hospital with shackles on my arms and my feet. But I knew within myself that I was in the right place, and that I was going to get help.

A lot of our youth today do not understand the results of addiction, of alcoholism, and of the lifestyle in which they are involved. The results are jails, institutions, and death. I have been there. But today, people have to realize that there *is* hope, that they can express themselves without flaunting fine clothes or gold. If they seek, they will find a spiritual sea that is within everyone. And it is greater than any gold, any clothes, and any voice anyone can share.

I believe the only way we can help each other is to join together and listen to each other. We can learn from the drug user and the drug seller because they are hard working and intelligent. They have business plans, and they feel they are going to control this planet some day. And we have to realize that they are determined to sell their drugs just as much as we are determined to stop them. But we have to have a powerful message and an overpowering desire to overcome this disease. A user has to determine within himself that he can stop. I do not care how much counseling he gets, how many psychological answers he has; if a person is closed-minded, he will not surrender. I believe that pain motivated me to get on my knees and humble myself to the God of my understanding. But how can we tell the drug sellers that they are doing wrong when they are driving in luxury cars and walking around with gold? The community draws to such people. They are looked up to as gods. But all of these images are false. And we have a way of breaking these images down.

You see, what we can do is lock them up. Those people who continue to disturb our community and cause this drug-infested environment can be put away. That

is the answer. When we keep letting drug sellers and drug dealers out in our communities, they feel that they have put one over on us. But they have to feel that pain, that emotional bottom, and become whipped. When they think they are on top, they will never surrender.

But today I also realize that many of our youth can express themselves in writing, culture, poetry, and painting. We can offer these things to our youth. Many of our youth enjoy theater; they enjoy special privileges to express themselves. They want to feel involved in our community. They want to feel important. They want to feel useful. We have to find ways and means to reach out. If we want to communicate, we must get on their level and ask them personally. We must take time out to listen and to get involved.

Today, through the grace of God, I have overcome many obstacles. Today I am proud to say I am a Youth Mayor of Washington, DC, and I have come far. But the only way I can continue to go on is to carry this message because I know it was only through that source of strength that I am here. And I know God has a purpose for me. You see, I am the youngest one in my support system. I went to school, and my friends pointed at me. They knew I had been in St. Elizabeth's Hospital. They were the same friends who knew every day that I used my lunch money to buy drugs. They remembered when I did not want to eat, to attend class, or do anything but use. But I was determined to stay clean, no matter what happened. I was determined to stay clean because I *remember* as well: I remember where I came from. I also remember being in a mental institution. I remember being chained up to a jail in the bullpen. I remember these things, and I pray to my God and ask him to help me to carry the message to those who are still suffering, those who are still blind.

I was involved in Mayor Barry's Youth Leadership Institute over the summer. During that time, we had an evening entitled "Suicide Among Teenagers." We lit candles. We had a very emotional evening. Many of our youth cried in that room. They cried out for love, and it was received from the others. We supported each other, and that was an accomplishment that we will remember for the rest of our lives. But it has to be a continuous effort to help each other. We have to allow ourselves to unleash those trapped feelings. Many youth were crying because they had thought of suicide, or their friends had committed suicide, or their parents had committed suicide. But they were determined to share these experiences with each other to stay alive.

We have the power to keep each other alive. We have the power to communicate. And that is where it is; that is what it is: communicating with each other to find the answers. Those who do not want help should not receive help. For those who do, we have a multitude of services to reach out to our youth. But if they are determined to sell drugs in our society, then they will never appreciate the source of that spirituality inside of them.

In closing, I would like to share what I shared with the youth. Searching from within, you will find a friend. It is more precious than gold. For that, friend, is your soul.

Primary Prevention from a Public Health Perspective: The Realities of the Urban Environment

Reed Tuckson, M.D.

As the Health Commissioner of the District of Columbia, I care very deeply about how a society, a city, organizes itself to facilitate the process of living. I am very interested in the quality and character of our civilization because it is the health care of a community that is a fundamental determinant of the quality of life for that civilization. Equally important, the nature of the society and the quality of the civilization are also fundamental determinants of the quality of health of that community. It should be fairly obvious that they are all tied in, and it is hard to know which comes first, the chicken or the egg. But ultimately I think that it is the health of a community that determines the quality of life of that community, and it is the quality of life in our community that determines the health of our community.

And so I am interested in the environment we create for ourselves, the attitude we have about ourselves, the people we love, the people we encounter, our collective sense of who we are as a community, and our individual sense of who we are as a single human organism—that is, our sense of self. Ultimately, it is that definition and the sense of who we think we are that will determine whether we make the appropriate decisions to guarantee a high quality of health for ourselves or whether we will have a high-quality civilization for our city and for our society.

We can look at the things that kill people in the District of Columbia—the big six. These are the same big six items that kill Black and minority Americans around the country. First is heart disease (cardiovascular disease, disease of the heart and blood vessels); second is cancer; third are diseases of chemical dependency, whether it be alcohol or other drugs; fourth are violence, homicides, and suicides, with homicide being the leading cause of death for Black men between the ages of 20 and 40; fifth is infant mortality; and sixth is diabetes.

The common factor in these six leading causes of death for Black and minority Americans is that they are diseases that occur because of how we live and how we behave. The leading and most common risk factor for the first two—heart disease and cancer—is cigarette smoking.

Why is it that 35 percent of Black men in the District of Columbia smoke cigarettes? For white men the rate is 17 percent. Is it because Black men are stupid, dumb, or genetically programmed to smoke cigarettes? I think it has more to do with a sense of who we are, a sense of the value of our lives, or a sense

of the relative importance and priority of competing demands. If we are burdened with the process of surviving from day to day, if the future is only as far as the nose on our faces, and that is all we see, then perhaps *not* smoking cigarettes does not mean very much because the last thing we have on our agenda is worrying about dying from cancer. What we are worrying about instead is crossing the street, or paying the rent, or trying to get the kids some new shoes, or getting some more drugs, or whatever seems important.

Unfortunately, Black women also smoke at twice the rate of white women in this community. Is it because they are stupid, or is it that they have other things on their mind?

One of the other things, of course, is how people specifically market cigarettes to poor folks. They do this because people with higher economic status do not constitute a cost-effective market. Companies will put the money where they have the best chance to make a profit, and they know that that is in the Black and Hispanic communities in this city.

So smoking becomes how we behave. It is our sense of who we are. We do not go to the doctor. We wait until the lump in the breast is as big as a baseball, and then we go to the doctor and say, "I'm in trouble." Why do we do that? Because we are afraid of interacting with the system; we are anxious about the implications of the disease. There are a number of issues here, but it ultimately comes down to how we behave. The result is that 1,480 people in this city died prematurely from the six diseases that I just enumerated. If our profile had been the same as white America's, there would be 1,400 more Black and minority people alive today.

Regarding violence, how did we get to the point where a young Black man says, "Look, you stepped on my foot. I'll shoot you!" Where does that come from? What sense of who we are, of our civilization, accounts for that kind of behavior?

What I am trying to get to is this: In analyzing the subject at hand—the primary prevention of drug use—we have a society, a civilization, that has some tragic realities. The first, and the one that is most important to me, is that our civilization raises children who have no concept of the possibility of a future. And when we cannot conceive of the possibility of a future, when we realize there are more Black men in jail than in college, when we look up and see that jails are so crowded that there have to be special court orders to halt crowding, and when we realize that those who are overcrowding the jails are the people from our own neighborhoods—our Uncle Jim and big brother Bob—it hits us and we say to ourselves, "Why postpone using drugs? What difference does it make? It doesn't matter anyway because there is no future. So I'll go ahead and do this to decrease the pain of day-to-day living."

There are those of us who are successful, who control some part of our world. And that is real. While this concept does not hold true for women, a major function of masculinity is a sense of control over one's environment. We may not like it, but it is real. Men who are successful get to control things. They get to determine things that will happen and that they will allow to happen in various ways.

By contrast, the young Black men on the street too often have no sense that they will ever control events. So how do they express their masculinity? The only thing that is left, the least common denominator, is to control women. So they control women and define their masculinity by the variety and frequency of their sexual conquests. Again, that is all they have left. So we say to young Black men in the AIDS era, don't do drugs and don't be sexually promiscuous, and if you are, wear a condom. And they reply that wearing a condom makes them feel impotent, which means we have just taken away from them the last thing they had to feel good about themselves as men.

When we start to try to address these issues as a society, as a public health commission, we are talking to people who really do not want to hear what we have to say. We can develop all kinds of wonderful messages, and we can package them in innovative ways, but we are talking to people who do not have the same mind set that we have or that we might want them to have.

And so for me the fundamental fight comes down to how do we create in our young people the concept that a future is possible? If we cannot do that, everything else is a waste of time. It took me a long time to understand that, and as commissioner of public health, I found that the best use of my time is working with people to develop those kinds of concepts and attitudes among our youth.

The second tragic reality of our community is the economic deprivation and the preoccupation that we have as a society for me, mine, now, and I want. *People* magazine, "Entertainment Tonight," "Lifestyles of the Rich and Famous" tell it all. It is all right there—the sparkling dream, the designer jeans, the new tennis shoes, the gold chains, the symbols of ways of being and of who we are. And our young people see that, and they want the trappings of success, the automobile, and the clothes.

And so what happens is obvious. Some people turn to selling drugs, acquire the symbolic representation of success, and become the heroes of the community. This is what we often find if there is no other way to make money in a community. Happily, we have the Mayor's summer youth program that has been extraordinarily successful. It needs to be continued and expanded into the nonsummer months. We have to have jobs for everybody who wants one even though there are precious few jobs. Yet for those who are dealing drugs, the amount of money

they make is absolutely incredible. And then they become the symbol of what is happening.

We are now concerned with trying to devise uniforms for the public schools because we know who sets the fashion trend for the school. It is not the honor student. It is not the captain of the football team. It is the drug salesman, the guy with the impressive boots and the expensive jogging suit. He is the hip, cool, "what's happening" trendsetter. And that is an unfortunate reality, but that is the kind of society we have. We are just as preoccupied as adults with the car we drive, the clothes we wear, and the symbols of what we think success is all about. And so that is what we foster. No wonder our young people accept it. So who becomes the hero? The people who profit on the misery and suffering of others.

What kind of a statement does it make that someone would give drugs to a pregnant woman in a city with the highest infant mortality rate of any State in the country? I get reports of every encounter that a pregnant woman has with the ambulance system in this city. Just the other day I received five of them. One woman, 5 months pregnant, was having a seizure on crack. How can that happen in a civilized society? Where was the rational person who saw the dealer give the drug to the woman, and why didn't someone call the police department and say, "Get somebody down here right now, and let's arrest this man for homicide or attempted homicide?" How can we have a community in which that would not happen as a matter of course? It is inconceivable to me that the quality of this civilization is at such a low ebb that pregnant women have access to narcotics. It is astounding to me that the people who sell narcotics could be considered heroic, that they could in any way be considered a symbol or role model for anyone. To pattern oneself on death is incomprehensible to me.

The tragic reality is that we are in the era of AIDS, and we have staff members, such as Gaston Neal, who go out into the shooting galleries. Given the reality of AIDS, how can people live in this city and not know by now that if they share needles, they are going to get this virus? How could they live in this city and not know by now that in New York City 70 percent of the addicts test positive for the virus? In Newark, 90 percent of the addicts may be positive for the virus. It is common knowledge that those who share needles are going to die.

Gaston goes into the shooting gallery and says, "You know you're not supposed to share your works, right?" And these guys say, "Yeah, I know what you're talking about, man. You're absolutely right," and hand the needle to the next guy as the blood is literally dripping off the needle. "Gaston, you're absolutely right. Here, here, give it back when you're finished." And so how do we deal with that degree of pathology and sickness? It is a tragic reality.

And then finally we have a tragic reality about our society that says we are so disconnected from the reality of ourselves, from the reality of life in our community, and so preoccupied with our own adult selfishness and concern about the "accounting bottom line," "our property values," and what is "mine" that we will not let a new treatment facility get established in any neighborhood in this city. I have lost every fight that can be lost in the politics of trying to establish a drug treatment center. It always comes back to, "Not in my neighborhood." In New York City, in Brooklyn, they say, "Not in my backyard." It is basically the same situation no matter where we go. "My property values are at stake, Doc, and if you put that drug treatment facility in my neighborhood, my property values will go down, and we're going to have a problem." Well, guess what neighborhoods are trying to put them in? You cannot get to their houses without fighting through the junkies.

"Well, they're going to commit crime, Doc." Seventy-four percent of the people arrested in the District have drugs in their system. What we do not see in their system is a drug called methadone. Those on methadone are not the ones who are robbing and stealing. The people in the treatment centers are not the criminals. They are in treatment. So it is crazy, but we get so confused. We do not know what we are doing any more. But "not in my neighborhood" because they are going to mess it up. The neighborhood is already messed up.

How do we work on that attitude? Because if we do not change that attitude, this primary prevention thing is dead. If we do not get to a sense that we are all in this thing together; that the life of this city is at stake; that how we behave as individuals counts; and finally, that how we come together as a collective society with our friends, neighbors, and relatives matters; that all this is the determinant of survival—if we do not get to that, then we are doomed.

And so the fight that we are waging now is the same old fight that has been around for years and years in the Black community. It is a fight for the minds of our people. If we think about revolutionary struggles and remember what a revolution is all about, every single day of a revolutionary struggle is important. Every act we commit is important because it occurs in the perspective of the promise of a future.

I think that somehow we have lost that sense of struggle. It is like we have won the fight because we can go and eat downtown. We get to go and spend our money on nonsense just like everybody else so there is no need to struggle. We give our kids the message that it is okay. And somehow it is a weird paradox because in many ways we are almost worse off now than we ever were before.

And so, that rekindlement of a sense of mission and struggle and energy is needed. We have to energize ourselves again. There has to be some other purpose to life than just owning expensive tennis shoes. The best people at communicating and influencing the behavior of young people in our community, the people

who have it down to an absolute science, are the men who make the tennis shoe commercials. A rap group can do a commercial for these shoes and say two words—only two words—but they are spoken in exquisite rhythm at the end of the commercial. They just say, "Buy expensive sneakers." And it is hip, and they capture your attention, and those kids are right on it.

Now, how can it be that those people who make those tennis shoes know how to manipulate the images and the symbols in a young person's life in a way that changes behavior in the most difficult way possible? What is the most difficult thing to get another human being to do? Reach into his or her pocket, take out the green stuff, and spend it on something. That is hard to do. And I am not just talking about a little bit of money. I am talking about $75 worth. Now how is it that we let them be better at that than we are? Do they know our kids better than we do? I think so. Do they set the agenda for our children in a better way than we can? I guess so. I mean, they have proven the point.

So what it comes down to is not only having the desire to do it, but also having the commitment to continue to do it and then having the technical skills that will allow us to do it. And it is the technical skills that we need more of. Once we have put the possibility of a future into a kid's mind, how do we present information to them in a way that they will use it, in a way that that information will be received and accepted?

And that gets to another whole set of discussions on which the drug treatment people are going to have to work. We are looking more and more at how we communicate information to young people, but I sure want the same technology that celebrities have when they sell malt liquor. Now, why is it that they only sell malt liquor to some people in this country? You do not see malt liquor advertising using Black celebrities in Iowa. For a certain market of people, they know how to make those symbols come alive. You pop a can of malt liquor, and a woman will magically come through the door. It works every time.

Another commercial for malt liquor duplicates the drug dealer's environment. It is a drug, isn't it? That is what it is. Go back and think about these commercials. A drug dealer pushing malt liquor is there, and the people come in and talk hip, with lovely women around. They say, "I want some of that," as he takes the order. They are not placing a bar order. They are placing a drug order, and nobody takes a tab. He does not go in and say, "I want to order a can of beer. Instead it is, "Hey, man, I want some of that bull." And it is all done with blue mirrors and smoke, and that sort of business.

So what I am getting at is that the malt liquor producers have a lot of people who spend a lot of time making that environment seductive to young people. And if they are going to have money spent that way, it seems that those of us who are in the business we are in ought to demand—as an element of the

civilization of this country—that they spend the same amount of money on antidrug commercials that use the same techniques, but in a positive way.

Let me end by saying that I hope we keep our sense of mission. I hope we keep struggling. We need to keep doing preventive work, but we also need to get out of the environment where we are doing it. We need to do it somewhere else—at church, at the civic association, at the Advisory Neighborhood Commission, and at the fraternity and the sorority. My hope is that the next time we go to a suite at one of the big hotels and we sit down with that brandy and all the other accoutrements of hipness, when they open up that little package with the white powder in it, someone among us would then go, "Achoo," and say, "Oh, I am *so* sorry." And then we could say to those people in that room, "You know, by the way, there are a lot of young people who think we are pretty cool, so why don't we redefine the elements of what cool is to say that we don't do this sort of thing. That is to say, we are against this kind of behavior." And by the way, let us put out the cigarettes. Let us just say to people, "There is a future to which I am headed, and in that future I can see a world in which we actually are doing and moving and creating and contributing and in which we have a sense of who we are, and this is not part of it, so we reject it."

And I would say the same thing to the women. We have got to go out and talk to those young Black girls about cigarettes; tell them smoking is not cool. *Essence* magazine gets 16 percent of its budget from the makers of death and disease; *Ebony* magazine, $2.5 million a year from the tobacco industry. So we pick up *Essence* and we try to go through all the hip articles, and we count five glossy spreads on cigarettes. "You have come a long way, baby." Yes, you have come so far that your risk of dying of lung cancer now outweighs your risk of dying of breast cancer. Congratulations! So the point I am trying to make is that primary prevention is not talking about drugs. It is the fraternities and the sororities and the churches and the civic associations. It is talking to young people about their sense of who they are.

Finally, we have some things of which we are proud. There is PARADE—Parents Rally Against the Drug Epidemic. We are trying to organize parents by getting them involved. The State is getting a little weary of trying to be the parent to all the children. It is pretty darn hard. When the kids go home at night, even if it is real, real late, parents are going to have to do their part. We just cannot have them say, "I don't know how Johnny got that jogging suit. It's a mystery to me." Come on, give us a break.

Finally, we are trying to see whether we cannot use the public school system a little better. They have been doing a lot of work. We are trying to coordinate a little better on that. But ultimately again, if it is the purpose of the school system to prepare a young person to live in a society, then the question becomes, "What is the society that we are going to prepare them to live in?" "What are

the ideas that we are going to give them?" Now, the school system cannot do a great deal about the society. If I was in charge of the school system, I would probably have to teach young people a whole set of skills that I wouldn't want them to have to live in this particular society at this particular time. That is not the school system's job. That is our job as parents. We have still got a lot of work to do.

I am pessimistic about the future. I will say that I do not see anything good on the horizon for the next couple of years. I see it being very difficult. I think that the AIDS epidemic, which is ultimately going to destroy the lives of many of our young people because of their sexual and drug-taking behavior, is going to reap incredible consequences on our community. But I also think that the AIDS epidemic will give us the opportunity for a fundamental restructuring of the urban experience in this city and around the country. I think that the threat that AIDS represents is so severe, so serious, that it will force us to change how we behave as a civilized or, in this case, an uncivilized society. If we are not allowed to have drug treatment centers in our neighborhoods, our community will be given a death sentence from AIDS. So we cannot sit back any more and say, "I care about the property." There will not be any property to care about. It will not make any difference, anyway. If we do not give our young people the concept of the possibility of a future and if we do not do everything we can, they are going to have sex all day long just as they are doing right now, and then they will not survive. We will be forced to make changes in our sense of who we are.

So in that, I will say that I am energized. I am still ready for the fight.

An Ecological Model for Prevention of Drug Use

Cecile H. Edwards, Ph.D.

Alcohol and other drug (AOD) use is a topic of national and international significance. I will focus on four aspects of the topic. First, I will give a broad overview. Second, I will discuss the outstanding characteristics of primary prevention programs, outstanding models, and outstanding strategies. Third, I will present the major points of the strategy session that I have shaped into an ecological model. Finally, I will indicate the rationale and the logic for each step in the ecological model.

Let us begin with the overview. The environments of adolescence are constantly in a state of flux—shifting and changing. The factors that cause the adolescent environment to be sometimes volatile, sometimes stable; the interventions that can mediate and positively focus the adolescent environment; and the ecological base for prevention of AOD problems are national and international concern. In human ecology we operate from the perspective of environmentalism, through which we seek to understand how human beings affect their surroundings and how their environments affect them in turn.

In planning strategies for prevention of AOD problems, I have looked at several models: the *homostatic* model, in which the addict and two parents are the major players; the *parental* model, in which parental socialization factors are used; the *risk factor* model, which depicts individual abuse on the basis of the number of risk factors; the *school-based prevention* model; the *lifestyle risk reduction* model, including church-based programs; the *work-site programming for interventions,* such as the successful program against smoking; the *media* model; the *social* model; the *intervention* model; and the *significant networks* model.

However, there must be linkages between community organizations and the schools if we are to come up with a viable approach. The *biopsychological* model is a fascinating one that has been developed recently by Royer Cook. The *distribution of consumption* model and others also are very important.

Let us look at characteristics of these models as a basis for developing strategies. Several major characteristics are relevant here. One, for example, is that the outstanding effective prevention programs are usually *comprehensive* in scope. They identify strategies for reaching their goals. They provide positive alternatives similar to, or more highly valued than, those served by health-compromising behaviors. They develop life skills. They train "impactors"—significant persons like the parents, the role models, and the mentors of our youth. They seek to change social policy frequently, to change community norms. And

they include a sound planning process, a collaborative type of venture structure, and realistic and measurable goals and evaluation procedures.

The most promising strategies for prevention can be classified under assertion training, cognitive behavioral skills training, decision skills training, and life skills training.

The most effective program models were identified by N.S. Tobler in a meta-analysis of 143 adolescent drug prevention programs. When she controlled for the outcome measure used in the program and for the rigor of the experimental design, peer programs showed a definite superiority for the magnitude of the effect obtained on all outcome measures. If the criterion of drug use was used, peer programs were highly effective in reducing the use of alcohol, drugs, and cigarettes.

To identify the strategies that have been presented, I will summarize briefly the three workshop group reports. Contributors to the chapter on "Prevention Models for High-Risk Youth: Health Care and Civic Organizations" discussed the formation of a network of national organizations in which technical assistance—for example, with data collection and evaluation—was provided to communities that were otherwise capable of organizing their own programs. Contributors also said that certain drug prevention projects appear to be viable. One such project seeks to raise the awareness of the members of a community about the health effects of alcohol and other drugs.

In the second strategy chapter, several important points were made. Emphasis was placed on reordering the value system; reevaluating the use of alcohol as a legal drug; getting communities to confront drug laws, drug usage, and policy issues; and exposing adults and children to as many positive options as possible with information. The interaction model was considered viable. Contributors discussed a comprehensive drug program providing prevention education, intervention, and treatment. They also discussed primary prevention programs as separate from treatment programs, and they said it was important to regenerate a neighborhood identity.

Several other points were made in the third strategy chapter. Contributors suggested that written materials be developed for testing children to determine parental AOD abuse. It was felt that Howard University should play a stronger role in prevention strategies and that the university should encourage youth around and adjacent to the campus to do something about the problem. These writers had quite a large number of recommendations: (1) there should be programs that offer monetary compensation to compete with money generated from outside sources; (2) the summer jobs program should be extended throughout the year; (3) incentives should be offered to draw youth into various programs; (4) career options should be identified for high school youth; (5) early identification should be made of children with problems in school; (6) profiles of

children who use drugs should be developed for prevention materials; and (7) alternative methods should be explored, including family strategies, child-rearing strategies, parent programs, and neighborhood- and people-organizing procedures. Finally, the contributors discussed the pros and cons of setting up one model program and then replicating such a program in other areas, addressing the economics and the politics of drug use not just locally, but on all levels.

In the literature on primary prevention research, Sussman (1987) holds that the primary prevention research that exists today has been based on the assumption of a simple, linear, unidirectional causal model. In human ecology, we view life from an ecosystems approach in which many events are interrelated. Therefore, a human ecologist views a causal model as failing to address a social world that is constantly changing and in which many elements are interdependent. Thus, it has been suggested by Bronfenbrenner, and more recently by Sussman, that an ecological transactional model, in which the cause is conceptualized in a reciprocal setting, is the most appropriate model for primary prevention programs. Myerhoff and White, after examining the lessons of Headstart, the Harvard Pre-School Project, and the Missouri Initiative, concluded that children should be reached during the first 3 years of life if a significant difference is to be made in their academic prospects.

Let us now consider alternatives that have proven successful but that, perhaps, may never have been thought about in relation to strategies for prevention of AOD use among youth. The first principle is to *work with our children early in life*. We should not wait until they are teenagers. This approach to education would offer exciting new opportunities and marshal the efficient and inexpensive support of the people who have the greatest influence on the lives of children at that time—their parents.

The second principle is that, *regardless of economic status, educational level, or cultural background, efforts to prevent AOD use must be mounted in the setting in which the child is reared: the home.*

The problem of AOD use by youth is overwhelming. The number of crimes committed by drug users is growing. The consumption of various narcotic substances is increasing. Men and the women who abuse substances regularly, daily, are likely to be the ones who create the greatest number of offenses to the public.

A third consideration is that *we must look at the domains of adolescent health—physical, social, psychological, and personal—to understand how to work with youth*. Health-compromising behaviors are those that include an increase in risks such as cancer and accidents. Problems identified under social health include delinquent behaviors, poor school performance, and interpersonal difficulties. Psychological health problems might include a sense of dependency, reduced self-esteem, a sense of external control, and apathy. And

under personal health, a number of items are relevant, including restricted exploration of opportunities for growth. These factors have been addressed in a health promotion strategy by others, and it is this type of strategy that is akin to the prevention strategy that we will propose in the ecological model.

The feature of the proposed model is based on the conviction that if there is a sense of togetherness (a shared vision, a goal that everyone is aware of and looks to) and if there is a positive culture feeling (everyone saying the same thing together), *a successful culture-based prevention strategy might be developed.* A sense of community, a sense of sharing, and a sense of shared goals are crucial to mobilize public support for an alcohol and other drug use prevention program.

Now, we can use these principles and the strategies developed in the previous chapters to conceptualize an ecological model for the prevention of AOD use among youth. The objective of such a model is to change the addiction to drugs to an addiction to learning by altering the psychological, intellectual, and support networks—indeed, the psychosocial and intellectual environments of the growing child—through enhancing the partnerships between the family, the school, the church, the community, the mass media, and the Government.

In the School of Human Ecology we believe that the training of parents and other persons who influence the lives of children (the future alcohol and other drug users and abusers) will make a significant difference. In education circles we are told that most children who encounter scholastic difficulty at age 6, in the first grade and beyond, are already by age 3 significantly behind their peers in terms of intellectual and linguistic skills.

When I recently went to Japan and South Korea, I was impressed by that extra surge of energy and interest in learning displayed by the Japanese and Korean children. Their commitment to education is so intense that one hears of suicides when Asian youth are not accepted into the university of their choice after graduation from high school. I asked people around and about and in various positions at Yonsei University and National Seoul University, and all of them said, "It's the cultural emphasis on education." Thus, if we are to change the 150-point disparity between Afro-American and caucasian SAT scores, we must change the addiction to drugs to an addiction to learning!

The objective and components of the ecological model are shown in figure 1. A sense of community, a shared vision, and a positive culture are parts of the plan.

If we are to prevent AOD use among youth—we must start with very young children—well before these children enter the teenage years. In recent surveys, it was shown that seniors in high school drank as much alcohol when they were in the 6th grade as they did when they were in the 9th grade or 12th grade. The habits were virtually the same throughout those school years. Several risk

OBJECTIVE:

TO CHANGE THE ADDICTION TO DRUGS
TO AN ADDICTION TO LEARNING

(1) BY ALTERING THE PSYCHOSOCIAL

(2) THROUGH IMPROVING THE PARTNERSHIPS BETWEEN

THE FAMILY

THE SCHOOL

THE CHURCH

THE COMMUNITY

THE MASS MEDIA

THE GOVERNMENT

Source: Edwards 1987
School of Human Ecology
Howard University

Figure 1. An Ecological Model for the Prevention of Drug Use

factors could explain these behaviors: low academic records, low religious affiliations, early cigarette use, high psychological distress, high stress in the life environment, low parent nurturing, high peer use of drugs, and high parent abuse of drugs.

It seems to me, then, that starting with the child before conflicts arise in a situation involving family members should be a feature of an AOD problem prevention model.

Parents are the ideal partners in an ecological prevention strategy because they have aspirations for their children. Most parents will do anything—scrub floors, wash dishes, iron, and so on—to help their children have a better life.

It is of interest that alcoholic fathers, when given a certain test, showed changes in heart rhythms. The sons of these alcoholic fathers showed the same changes. When a placebo (a pill without the alcohol) was given, just the thought, just the expectation, that the person was going to get alcohol caused that same shift in heart rhythms for the alcoholic. But the son of the alcoholic did not so respond. The heart rhythms of babies with Fetal Alcohol Syndrome (FAS) also are different from those of normal babies. You can tell when a mother has

smoked or has been an alcoholic by simply looking at the polygraphic tracings of newborn infants.

Parents want strong and healthy babies. They want the very best for their children. They want a better quality of life than they had. Therefore, parent education in infant stimulation, in the penalties for drug use, and on the art of parenting—these are all important components of the ecological model.

In a program fostered by the Food and Drug Administration, ADAMHA, the negative effects of alcohol on pregnancy were studied. Significantly decreased birth weights were observed among children of women who drank only 1 ounce of alcohol per day during pregnancy. Spontaneous abortions increased. A woman who consumes alcohol, at the level of a diagnosis of alcoholism, risks bearing a child with the specific cluster of severe physical and mental defects. Many parents have doomed their children to being at risk for the health problems before the children were born!

Schools play a very important role. Schools have always been a popular setting for primary prevention programs. And although there are questions as to the appropriateness of a school as a setting for prevention efforts, problems relating to health, social adjustment, sexual activity, and drug use are addressed in many schools through educational programs that aim to regulate the onset of problem behaviors. Schools can cooperate in a comprehensive prevention effort that involves families, community groups, and the media. They can include alcohol and other drug use prevention as a part of a comprehensive, integrated, grades K through 12 health education program. They can focus specifically on knowledge, attitudes, and behaviors that influence use by youth of AOD. And they can develop programs based on a promising new approach, the *social-psychological* model.

The training that is given to drug users has been shown to be effective in changing—that is, reducing—drug use. Drug education in the schools is an important component of the ecological model.

We will look now at the media impact. "Say no to alcohol," "Say no to drugs," "Say no to pills," "Say no to injections of cocaine and heroin and other drugs" are all very positive statements. When a comparison is made of the psychological processes of change going from exposing the person to the information to grabbing the person's attention, the person then begins to comprehend after more information, believe the message, make the decision to alter habits and behaviors, and, in the course of it all, learn. In a group of high school seniors that were queried about cigarette smoking, a larger number in 1985 than in 1975 perceived the harmfulness of smoking. Therefore, we believe that the media can make a difference.

The Government also has an important part to play in this effort. Research by the National Institute of Justice is helping us to develop effective policies for cutting off drug supplies and reducing the demand, especially among criminals. Crime in America is closely related to the use of illegal drugs. More than half of all the criminal arrestees in New York and Washington, DC, show a positive drug test result at the time of arrest. Federal, State, and local governments can develop policies that help us prevent AOD use by youth. Programs such as those we have in the National Institute of Justice and the Department of Health and Human Services are effective in reducing drug use among youth. But the Government must also devote budgets—that is, money—to attacking the problem. We need funds to feed into the system to decrease the opportunities for drug use by youth. Not only do we need funds from the Government, but we also need jobs, jobs, jobs!

In summary, I have presented an ecological model in which the child is the focus. Environmental stimulation and values from socialization will come to the child from the parents, but we need to train the parents. We need to give them parent education, if you will, to teach them how to teach their children. Remember the adage, "If you give a man a fish, you feed him for a day. If you teach a man how to fish, you feed him for a lifetime." Paraphrased, if we send our children to day care programs, they will be given fish in a sense. But if we teach parents how to teach their own children, the children will grow and prosper in the early years of life.

Parents must be the children's first teacher. We must not wait until our children are 3 years old. We must start as soon as infants are born. Therefore, parents should have training programs, which would be a marvelous investment by the Federal Government.

Newly trained parents will be equipped to give the child—the infant—the environmental stimulation: opportunities to search and explore, to be creative and to be inquisitive, and to find answers and to solve problems. That is really what life is about—solving problems.

We need also the involvement of several types of institutions, agencies, and organizations. These include the schools, the church, the community groups, the family, the mass media, the national fraternities and sororities, and the industries, because they will provide not only motivation and support networks, but also opportunities.

But these agencies and groups also will give something else that is very important: role models. And in addition to the role models, there should be mentors, persons who can help develop that sense of worth in the child, can give a child hope, can show the child a vision of what the future can be and can help the child realize that vision.

BEGIN WITH THE CHILD

PROVIDE

(1) ENVIRONMENTAL STIMULATION (PARENTS)
- INTELLECTUAL
- PSYCHOSOCIAL
- NUTRITIONAL, PRENATAL AND POSTNATAL

(2) MOTIVATION AND VALUE SOCIALIZATION (PARENTS)

(3) MENTORS AND ROLE MODELS

(4) OPPORTUNITIES

(5) SUPPORT NETWORKS
- FAMILY
- CHURCH
- COMMUNITY

Source: Edwards, School of Human Ecology 1987

Figure 2. An Ecological Model for Prevention of Drug Use

These components of the ecological model are shown in figure 2. Parents would be trained to provide environmental stimulation and value socialization, which would identify learning and getting an education as the prize to be sought and the negative effects of drug use on mind and body. During the child's formative years, role models, mentors, and drug education would be provided by Government, church, communities, school, fraternal organizations, and the mass media. Children would thus be motivated to stay drug free, and would be offered support networks and opportunities including jobs. Working together—and the key word is together—in an interdependent way, these groups would form a partnership to prevent AOD use. Together, these can make a difference in a child's life.

This model nurtures the hope that preventive strategies can be developed that will contribute to an important breakthrough in AOD use by our youth. The preventive strategies that have been discussed and developed can be defined

more precisely and, like breakthroughs in science and medicine, may have a significant effect on reducing AOD use. Why not start with young children and train them in the way they should go? We are reminded of the saying that when children get old they will not depart; we know there is something about that early training that stays with us. How many parents have told children what they should do, and then, when we thought all else had failed, they did what we told them and they survived?

We must continue to work together to change from a preoccupation with reduction and elimination of negative individual outcomes to the idea of prevention. We must seek to prevent AOD use among youth by developing positive images, support systems, and methods and strategies to achieve positive outcomes in people at risk for AOD problems.

Societies are made up of individuals, and we may end up being the people who make the difference in a young person's life. We can be mentors. We can be role models. We can reach out to one of the youths who might be going out to that corner where drugs are being sold.

The problem is so massive and so pervasive that it may not be resolved in our generation—not in my lifetime, not in your lifetime—but we can try. Perhaps we can make a start. This volume will go on record as making a resolution for this goal.

CHAPTER 2

Panel Session Summaries

The Incidence of Alcohol and Other Drug Use

Participants: Dr. Wilbur Atwell, *Moderator;* Mr. Kevin McGowan, *Co-moderator;* Dr. William Burrell, Mr. George McFarland, and Dr. Tom Harford, *Panelists;* Dr. Barbara Harland, *Recorder.*

Dr. Harford: We have three major functions in the Division of Biometry and Epidemiology at the National Institute on Alcohol Abuse and Alcoholism. First, we administer and maintain an alcohol epidemiologic data system. Second, from the data system, we do some in-house secondary analyses of the data sets as well as generate surveillance reports with respect to traffic fatalities, liver cirrhosis, tracking per capita consumption trends, and things of that sort. Finally, we also direct an extramural grant program.

We looked at the results from two current national surveys. One was conducted by the Alcohol Research Group in Berkeley, California, which looked at drinking practices nationally and among minority populations in particular; the other was the 1984 National Institute on Drug Abuse (NIDA) household survey with respect to alcohol.

At a national level, the percentage of adult abstainers tends to be somewhat higher among minority populations, both Blacks and Hispanics, and considerably higher among females, especially minority females. A similar pattern emerges for the young adults in terms of ever having used alcohol or having used alcohol within the past month; the rates are higher among whites, both male and female, and lower among both male and female Blacks and Hispanics.

These data are of interest from several points of view. First, when we look at other indicators of alcohol abuse consequences—for example, alcohol cirrhosis and cancer of the esophagus, both of which have been highly related to alcohol consumption—these rates are conspicuously higher among Blacks, and in the District of Columbia, the rate of esophageal cancer is three times as high here as it is in other parts of the country. That fact raises a puzzle with respect to self-reported lower prevalence of alcohol use among Blacks and minority groups and to any attempt to account for the high rates of cirrhosis mortality among Blacks compared with whites.

Table 1 shows results from the National Survey of Alcohol Abuse. The category of "frequent-heavier drinkers" includes respondents who report having six or more drinks per occasion and drinking at least once a week or more. Thus, the number of respondents who meet the criteria is high.

Table 1. Alcohol Use by Sex and Age

Drinking Pattern/Age	Men			Women		
	White	Hispanic	Black	White	Hispanic	Black
Abstainer						
Ages 18–29	16	22	23	22	40	34
Ages 30–39	13	17	15	30	45	32
Frequent-Heavier Drinker						
Ages 18–29	51	41	33	20	10	12
Ages 30–39	48	54	50	21	6	10

Source: National Household Survey on Alcohol Abuse, 1984

When we look particularly among males between the ages of 18 and 29, practically half the white population falls in this category, followed by Hispanics at 41 percent, and finally Blacks at 33 percent. With increasing age, however, both minority groups catch up with the white males.

This finding was complemented in the NIDA survey, data from which are shown in table 2. It has also been demonstrated in inner-city studies in St. Louis, which used much cleaner diagnostic criteria with respect to alcohol abuse and alcoholism, as well as studies in rural areas in North Carolina and Florida. Thus, with respect to both national household survey reports and some regionally specific studies using more sophisticated diagnostic criteria, there is general agreement that among young adults, the rates are lower for minorities, particularly for Blacks, relative to whites. With increasing age, however, there is a conversion between these rates.

That situation certainly has some implications for intervention and prevention. It is always easier to stop something before it is started. So with regard to high-risk young adults in minority groups, there is some encouragement for intervention. What we need to do is get beyond the prevalence figures here and attempt to understand the pathways to and away from abuse.

Again, I would like to emphasize that when we are looking at national studies and household populations, there is a great deal of heterogeneity within these

Table 2. Alcohol Use by Sex and Age

Alcohol Use/Age	Men			Women		
	White	Hispanic	Black	White	Hispanic	Black
Ever Use						
Ages 12–17	62	50	44	60	39	35
Ages 18–25	97	88	82	96	74	78
In Past Month						
Ages 12–17	36	27	24	33	19	18
Ages 18–25	81	74	67	70	42	49

Source: National Household Survey on Drug Abuse, 1985.

groups, particularly among Hispanic and Black populations. There are some diverse patterns within urban areas, such as combination alcohol and other drug abuse among Blacks. However, we do not have enough specific studies looking at joint-use patterns among the urban minority populations to be able to provide a precise estimate of prevalence.

Dr. Adams: The concern over cocaine and young people centers on crack, which is a smokable form of cocaine and is, at least initially, cheap. On a price per gram basis, it is actually more expensive but, in terms of removing that initial price barrier, it is cheap, roughly $10 for 67 milligrams. What we are seeing in the high school senior survey—and these are kids, again, who have made it to their senior year in high school—is that about 25 percent of those who have used cocaine have smoked it, and among the 12- to 17-year-olds, over 40 percent of those who have used cocaine have smoked it. So in terms of prevention, we are really talking about an increasing problem with smoking cocaine. And that situation is also seen in our emergency room statistics, in which the smoking of cocaine has gone from 3 percent a couple of years ago to 26 percent today.

As to whether students are using it during school, before school, or after school, all I can say is that they are probably using it at all those times. Some studies have shown that it is used at almost any time. Lots of people use it before they go to school.

In terms of our high school senior survey, the question was asked whether they use it with friends or alone, and in what situations. As to whether they use it before, during, and after school, I would have to go back and look at the data.

Mr. McFarland: I am going to talk specifically about alcohol and other drug (AOD) problems in the District of Columbia, where we have a population of roughly 627,000 residents.

Unfortunately, a third of all deaths in this city each year are premature. People die before we would normally expect them to die, and the problem is broader in scope than one of AODs or of any single drug. It seems that what we are really looking at is lifestyles that result in poor health and premature deaths. There are conditions in our community that predispose city residents to extraordinary risks that result in death.

In particular, there is the problem with cancer, especially among Black males in this city. Howard University's Medical School did a study several years ago that looked at the unique cancer problems in this city related to tobacco. We forget tobacco because it is not an illicit drug but we should begin to examine it as a gateway drug.

Throughout the country, cancer of the esophagus, of the larynx, and of other sites related to the ingestion of both cigarette smoke and alcohol accounts for roughly 10 times as many deaths among Black males as among white males. Moreover, nationwide, Blacks also represent more than twice as many cirrhosis deaths when compared with whites.

The District of Columbia ranks first in per capita expenditures for distilled spirits, as measured by the Distilled Spirits Council, which means that we are buying, selling, and drinking a lot of alcohol.

I brought a copy of the alcoholic beverage industry newspaper that I found very interesting. It's called the "Liquor Handbook," and it makes the following points: (1) Blacks represent only 12 percent of the population, yet they account for 20 percent of all alcoholic beverage consumption; (2) when they purchase alcoholic beverages, Blacks tend to buy larger amounts: fifths, quarts, and gallons; (3) among the most lucrative target areas for alcoholic beverage sales are center-city areas, largely populated by Blacks; (4) nobody in the alcoholic beverage industry can hope to be number one in sales without capturing a major share of the Black market; and (5) Black Americans are the heaviest per capita consumers of distilled spirits and form a disproportionately large section of what is becoming the dominant youth market.

It has been observed that the Black consumer is being heavily targeted for certain alcoholic beverages in particular. In fact, Blacks purchase 75 percent of some malt liquors. Some of these particular malt liquors are of high concentration, 20 percent alcohol, and are targeted specifically at the Black community.

It was also interesting that one recent issue of *Ebony Magazine*, which has our largest Black circulation and claims to reach 46 percent of Black families, carried no fewer than 12 full pages of alcoholic beverage advertisements.

So what we are largely seeing are Black newspapers and magazines all making a big pitch to both college students and the Black population in general.

According to a Black newspaper network, 87 newspapers in 78 markets are trying to reach 4 million consumers, and they have a very systematic way of getting the message to the Black community. Thus, our job becomes even more enormous.

Using projective techniques, my colleagues and I at the Alcohol and Drug Abuse Services Administration (ADASA) estimate that there are approximately 73,440 problem drinkers in the District of Columbia. Very often these numbers are difficult to conceptualize in terms of people, but that many people could not fit into the Robert F. Kennedy (RFK) Stadium to watch a Redskins game.

Nor could the number of heroin addicts—roughly 18,000–19,000 in the District—fit in the Capital Center, the home of the Washington Bullets. But if you have ever been to the Capital Center and heard the noise and seen the number of people included in a group of this size, you have an idea of the magnitude.

I give these examples because I think the numbers come out cold without some kind of context that is familiar to us. The problem transcends statistical information, however, in that it relates to the quality of life. Thus, in any effort that deals with prevention in this city, we must go beyond concern about specific drugs and their effects and focus on improving the quality of life.

Unfortunately, the District's approach to the drug problem has instead placed primary emphasis on enforcement. Currently, 25 percent of all police activity is devoted to drug-related activities. Roughly 23,000 people were arrested last year as part of Operation Clean Sweep, our current police initiative, and about half of those people were arrested for drug-related offenses. Clearly, the outer edges of this problem are enormous.

In the District we now have situations in which 13-year-old kids are arrested for dealing drugs. They do not understand why they are arrested because they have $6,000 in their pockets and they share that money with their mothers, fathers, uncles, and aunts. Over 2,000 kids under age 18 were arrested last year for drug offenses.

For the most part, although we have a severe problem of alcohol abuse in this city, all our attention now is being focused on cocaine and PCP. Each month, ADASA tests over 6,000 urine samples and roughly 66 percent of those people test positive for some drug, primarily cocaine and PCP. Moreover, from the urine test results of the more than 12,000 people who were arrested last year specifically for drug sales and possession, we found that roughly 68 percent of those people tested positive for one or more drugs. If a new drug that was cheap and readily available and produced satisfactory euphoria were to come on the market tomorrow, it would become the new drug of tomorrow. We are in a market of competition for drugs that represent the best value.

So we have a very serious problem, and unfortunately, too often we play a kind of merry-go-round game. Increasingly, the people who come to ADASA, about 62 percent, are sent by the criminal justice system. However, a closer inspection of the source of referral would probably show that roughly 97 percent have had some involvement with the criminal justice system.

Very often the game being played includes a person who has been arrested and whose case is coming up before a judge. That person will come to us as a self-referral when, in fact, he is trying to influence future transactions with the judge. So the problem resembles that of babies falling off a conveyor belt and we are trying to catch them in the basket. The problem gets at the heart of our moral values. I think we have really lost control.

The average age of the treatment population at ADASA is increasing largely because the people who started some years ago are continuing in methadone treatment. If you visit the building where I work at 1300 First Street, NE, around 1:15 p.m., you will see between 200 and 300 people leaving that building. These are men and women who started methadone treatment with us in 1968, who have been in and out of treatment for 20 years, and who are now grandparents.

Interestingly, only a small percentage of our clients in methadone treatment are arrested. This finding supports the notion that methadone may forestall, delay, or eliminate a lot of the criminal activity related to drug use. Unfortunately, in this city, methadone has been unfairly given a bad reputation. So we are increasingly forced to rely on abstinence as the primary mode of treatment, and we are just not getting the results we hoped for. We find that a large percentage of these people drop out of treatment within 3 weeks. If they stay for 3 weeks, as soon as their case is adjudicated, they leave and are frequently and repeatedly rearrested.

At ADASA we have seen a big resurgence in the number of narcotic overdose deaths in the past several years. In 1978 I think we had seven such deaths. Since 1984 we have been seeing an average of 144 narcotic-related deaths per year. This total averages out to about 12 deaths a month.

Regarding the abuse of pharmaceutical drugs, the urine tests we do are revealing a low level of drugs other than opiates, cocaine, and PCP. Recently, however, there has been a substantial increase in the number of deaths associated with synthetic opiates. There seems to be a direct relationship between the lack of heroin and the increase in availability of synthetic opiates. In other words, as the availability of heroin increases the use of synthetic opiates declines and vice versa. Among our new admissions, however, we are seeing relatively few heroin addicts. We have also seen a tremendous increase in the number of hospital-related emergencies—particularly in the District—as they relate to

PCP and cocaine. And we have begun to see more and more deaths that are associated with cocaine intoxication in the city.

Perhaps the good news, if it can be termed good news, is that thus far a relatively low percentage of ADASA's AIDS-related cases—only about 7.28 percent—have been associated with IV drug use. Right now that proportion does not seem to be changing very much.

We do an annual survey of alcohol and other drug use patterns among youth in the District of Columbia. In the past school year, we surveyed 3,000 youth along the same lines as the national studies conducted by National Institute on Drug Abuse. In general we found that the prevalence of PCP use among District youth is more than double the national prevalence rate. Approximately 13 percent of District junior and senior high school students have used PCP at least once. Of those students, about one out of five use PCP at least weekly.

The rate of PCP use rises dramatically between the 8th and 10th grades. Use is reported at 3.5 percent among 8th graders and at 19 percent for 10th graders. By the 12th grade, use reaches 21.34 percent of the city's students.

One of the interesting things about the District's AOD problems is that in too many instances the first source of AODs for students are parents. We tend to place a lot of emphasis on the peer influence. However, one of the things that makes the District of Columbia stand out is that AODs are widely available in the household.

My own bias in terms of prevention is that we have looked to the school, we have looked to the Government, we have looked to everybody outside the family to help resolve the problem. We have put all of our emphasis into enforcement and our results have not been encouraging.

We need to do more than just say no to drugs. We have a serious problem here that needs a lot of attention. And, I am not certain that we can go past the mothers and the fathers, who brought these children into the world, to play a major role in the development of attitudes and behaviors that discourage AOD use among youth.

What we need are some bold, new initiatives to get at the root of the problem. Unless we do something radical within the next few years, we will probably have lost two generations of Black kids to drugs. As I say, you only have to come to our clinic between 7:30 and 10:00 in the morning to see the grandmothers and grandfathers coming in, and now, often, they are bringing their nieces and nephews and their grandchildren into our clinics.

Our jails are full or above capacity, and right now we really don't have any sound solutions. The problem is a complex one, and it must be addressed within all institutions that nurture individuals without respect to race, creed, or color.

Many of the drug problems are generic and are caused by many other problems that must be identified. We have to find ways to develop the persistent kind of family support and encouragement that is required to turn individuals away from seeking a drug-induced euphoria. People want to feel different from the way they feel normally and I think there are reasons why. Stress is one problem. Unemployment provides stress. I am employed and so I am supposed to be here this morning at a certain time. Work fills my day. It produces a check that gives me some sense of value, some sense of worth.

Nationally fewer and fewer young Black students are entering college. This situation is unhealthy for the country and it is especially unhealthy for the District of Columbia.

Too many young kids with gold rope chains and beepers are riding around in expensive cars. They really play games with us in the treatment community. They drive up, run in, and give their urine sample, or run in and holler at the counselor, and they leave. It is a pathetic game that they are now winning. Prevention programs must coordinate services to address all of these problems, such as stress, unemployment, poor self-esteem, materialistic values, low educational achievement, and the lack of family support if they are to be successful.

Dr. Burrell: I would like to address the relationship between alcohol and socialization. To personalize this issue, when I came to Howard University, I was not a drinker. I did my undergraduate work here. But by the time I left 4 years later, in order to be accepted and be a part of what was going on at the college at that time, I was a full-fledged drinker. The same was true when I got my first professional job.

So it seems the whole issue of AODs is a large part of socialization in this country. Until we begin to focus in on that fact and address that, I do not think we are going to do anything about eliminating the problem.

The other thing is related to the fact that so much of our industry, so much of the American society, is caught up in this whole business of AODs. We know that all our major sports events are sponsored by the alcohol and, to a lesser extent, the drug industry. So, are we really facing these issues? Is society as a whole willing to pay the price of having certain segments economically devastated by reducing this focus, this emphasis on alcohol and other drugs?

Also, in years past, I, too, had heard the myth that drugs were permeating the Black community and that as long as they were held there, there was not much concern on the part of society as a whole. It was not until drugs began to expand into Montgomery County, where I live and near your offices, that there began to be a much larger focus on this whole issue of drugs. Is there any truth to that? And if so, what has been the impact on those of us who are part of this community?

Finally, given that we are fully aware now of the adverse impact of AODs on our society, are our institutions of government, at all levels, ready to take on the responsibility that is required? I refer back to the factors that cause stress: unemployment, health problems, lack of education, and illiteracy. These are the things that lead our people into AODs.

I am proud to say that for the first time, our agency, the Department of Labor, has finally recognized that Black and Hispanic males are at risk, and consequently, it is reallocating its budget to do something about the employability of Black and Hispanic males in the central cities. Are other governmental agencies willing to take that stand and acknowledge that they have done a serious disservice to our Black male population, and are they now willing to realign their budgets and their resources to address those issues?

Family, Cultural, and Environmental Risk Factors Related to Alcohol and Other Drug Use Among Black Youth at High Risk

Participants: Ms. Donna S. D'Almeida, *Moderator;* Mr. Keith Jackson, *Co-moderator;* Dr. Wade Nobles and Dr. Jeffrey Swanson, *Panelists;* Dr. Wilbert Wilson, *Recorder.*

Dr. Nobles: I'm going to try to raise some notions that I think are critical to the guidance of developing models for alcohol and other drug (AOD) problem prevention.

First, I would like to talk about the psycho-cultural analysis of Black family viability, and suggest to you a model of looking at the Black family in its standard form. This approach is different from what we are accustomed to doing, which is to look at the Black family as some deviant or deviate form of white families. We cannot accomplish the task of Black family retransformation until we have clear in our minds some agreed-upon standard structure, so I want to suggest some of those features to you.

Second, I want to report on a study that we've just completed in Oakland that deals with the emerging drug culture as a lifestyle issue and how it is affecting the deterioration of the Black family.

I suspect that the exchange of traditional Black family culture for the emerging drug culture is far more devastating and will have far more long-term effects on the Black community than we anticipate, given the scope of AOD abuse problems.

Third, I would like to suggest a cultural paradigm for permanent prevention based on the framework that we've developed at the Institute for the Advanced Study of Black Family Life and Culture. The core of family transformation is a cultural issue. If we don't utilize the technical specifications of African and African-American culture, we'll fail to achieve effective prevention, intervention, or remediation programs for Black people.

Let me quickly spend some time trying to develop and explicate the technical specifications of Black culture. It's a framework that is critical for us if we are going to begin to talk about what cultures do.

Technically, culture is the vast structure of language, customs, knowledge, ideas, values, and beliefs that provide people with "a general design for living and patterns for interpreting their reality." As such, culture emerges as a dynamic human system of features, factors, and functions with sets of guiding

principles, assumptions, conventions, beliefs, and rules that permit and determine how members of a group relate to each other and develop their creative potential. Accordingly, as most cross-cultural psychologists know, when the symbols, rituals, and rites of one's culture lose their legitimacy and power to compel thought and action, then disruption occurs within the cultural orientation and reflects itself as pathology in the psychology of the people belonging to that culture. This point is extremely important because nothing human (including pathology and its treatment) happens outside of culture.

For the most part, academicians, particularly non-Black academicians, have tried to talk about Black culture, or African-American culture, in two veins. One, the argument was that Black folks had no culture—that it was lost during the middle passage—and that our culture is a kind of creation that occurred as part of the experiences of living in America.

The second, related theme is that Black folks have a deviant culture—a result of emerging from slavery and not quite understanding what our "displaced" culture was.

Most of these themes centered around what we call cultural manifestations or the exhibited behaviors that can be identified as culturally based, and not the substance or underlying principles of our culture. As a consequence, African and African-American culture is generally misunderstood. So we attempted at the Institute to delineate some technical specifications of our culture as a guideline or a framework for understanding our social reality. We have argued in other contexts that African culture and African-American culture are based on principles that are very much like laws or rules that shift, change, and modify depending on the time and space in which one finds oneself. The core of African and African-American culture rests on the issues of ontology, cosmology, and axiology.

These issues determine the psycho-behavioral modalities that you see in our people's behavior as well as the context within which they operate. Concrete conditions (unemployment, poverty, racism, and such) and cultural substance (themes, values, practices) determine psycho-behavioral modalities (adaptability, respect, restraint, cooperativeness vs. selfishness, individualism, hostility, impulsivity, violence). In African-American culture, the ontological principle of consubstantiation essentially says that Black people are of the same stuff, the same spirit, the same essence. That finding is identifiable in many different ways. On the positive side, the historical experience of Black people in this country coming together to form Black churches, benevolent societies, and Black political movements was based on the theme of what's good for all of us as opposed to what is good for the individual. A similar theme—"I am because we are, and because we are, therefore I am"—reflects an integral connection between our collective identity and our individual identity.

On the negative end, we tend to take affront and be personally insulted if a Black person moves beyond what we consider the boundaries of our Blackness or moves up or away from us and begins to talk as if he were different from us. There's almost a knee-jerk negative reaction to such behavior in the Black cultural framework. In a purely individualistic framework, what one individual did or said would not meet with such universal disapproval.

Such issues as cosmology, ontology, and axiology ultimately take form as a people's cultural orientation. We are going to see in a few moments that the cultural orientation in the Black community has been going through a process of shifting over a fairly long time, but with the advent and intensity of drug trafficking and drug-related behavior, that shift is occurring far more rapidly than we ever imagined. In fact, the most fundamentally deleterious effect of the emerging drug culture lifestyle is that it is producing an erosion of the historically viable Black family cultural system.

The institute's longstanding research on Black family dynamics has fairly well established that healthy functioning Black families operate from a cultural orientation that provides effective "guiding" themes and positive values.

In fact, African-American culture, as a system that provides Black populations with a general design for living and patterns for interpreting reality, comprises the cultural themes of senses of "appropriateness" and "excellence." The cultural guiding theme of appropriateness literally requires that behavior be governed by rules of deference, relation, and formality. Within traditional Black culture, the way one relates to another is determined by the relation one has to the other and an intricate system of rules governing deference and formality. The appropriateness of one's behavior is governed by the person with whom one is interacting and the situation in which the interaction is embedded. Hence, one does not behave in the presence of elders (i.e., respect for elders) or members of the opposite sex in the same manner that one behaves with peers or same-sex age mates. Nor does one behave the same way in church as one does "in the streets."

Following this vein, you would listen to your uncle, even though you had a Ph.D. and your uncle had no formal education but had spent 20 years working on the railroad. When your uncle spoke, your Ph.D. did not get in the way of your understanding that it was time to listen because a sense of appropriateness says elders are to be respected.

Similarly, human conduct from an African-American cultural perspective is governed by the sense of excellence. The cultural guiding theme sense of excellence literally requires that behavior be governed by the necessity to be the best, to seek goodness, and to achieve the highest honor. Within this theme, there is a rule that allows for the need to have personal style in accomplishing

tasks. This results from the complementary desires to do something perfectly but in one's own style.

You see this in most areas where Black folks excel. We will do things, but we do them in a particular way. Black basketball stars all perform the task of basketball, which is to put the ball in the hoop (a simple task); the ways they do that task are so varied and so different, but all are perfect. That notion of excellence is paramount.

This rule often guided Black families traditionally, to tell their children in a very clear and understanding manner about racism; that you have to be twice as good as the white man in order to succeed, and that you have to be perfect in what you do. At a time when Black communities were developing and we were beginning to go into areas in which we had no history, Black mothers and fathers would tell their children, "I don't know what it means to be a psychologist, but if you are going to be a psychologist, you be the best psychologist you can be. If you are going to sweep floors, you sweep the floors the best that you can." There was an admonition in our cultural frame that spoke to this notion of excellence.

The cultural orientation is also captured by a set of value systems. It is important for us to recognize that we have some values, and that if we are going to reclaim our community we have to build on our traditional values and not the mutations of values that occur from racism, oppression, and other deviant forms of social interaction.

The cultural values that we identified as a part of the traditional Black community and Black culture have to do with notions of righteousness, mutual aid, justice, adaptability, truth, spontaneity, and respect. Respect for the elders in particular is sort of the hallmark of Black culture, and we are now seeing even it begin to crumble.

Restraint, responsibility, interdependence, and reciprocity are also key. You may recall that most of these cultural values were instilled in us with proverbs, with little statements of folklore, or with notions about what it means to be a human being. These notions are cultural themes. Technically speaking, these dynamic affirmations structure the nature of reality.

The emerging drug culture, as we see it, is antithetical to African-American culture. From the perspectives and testimony of former participants in the drug lifestyle and consultants, experts, and observers of drug-related activity, the institute's staff was able to explicate the features of the emerging drug culture. In contrast to African-American culture, the general design for living in the drug culture is (1) trust no one and (2) anything is permissible. The subsequent rules by which one lives and the value system guiding one's behavior in the drug lifestyle emphasize selfishness, individualism, violence, hostility, impulsivity, and so on. Hence, with the emergence of the drug culture as the dominant

environmental influence in the lives of Black families and children, we are witnessing a shift in cultural orientation (see table 1).

Table 1. Shift in Cultural Orientation

Black Family Cultural Orientation	Drug Culture Orientation
I. Cultural Themes	I. Cultural Themes
•Sense of appropriateness	•Anything is permissible
•Sense of excellence	•Trust no one
II. Cultural Value System	II. Cultural Value System
•Mutual aid	•Selfish
•Adaptability	•Materialistic
•Natural goodness	•Pathological lying
•Inclusivity	•Extremely violent
•Unconditional love	•Short-fused
•Respect (for elders)	•Individualistic
•Restraint	•Manipulative
•Responsibility	•Immediate gratification
•Reciprocity	•Paranoid
•Interdependence	•Distrustful
•Cooperativeness	•Non-family-oriented
	•Not community-oriented
	•Self-worth = quantity

As more and more Black families and children begin to internalize the laws and rules of the drug culture, so too will we see the permanent, and possibly irreversible, change in the nature of Black families and children. It is especially worth noting that the behavioral patterns (i.e., persistent pattern of dishonesty, irresponsibility, and callousness without signs of remorse, personal responsibility, or motivation to change) consistent with the features of the emerging drug culture are in fact reflective of the most devastating psychiatric malady, the psychopath. As the producer of a psychopathic environment, the emerging drug culture and the subsequent cultural shift is the clearest and most present danger confronting Black children and families.

Essentially, the drug culture is one that emphasizes immediate gratification, a sense of hedonistic pleasure, and lack of concern for others. For individuals and families involved in the drug culture, the drug-related behaviors and the pursuit of the means necessary to sustain the drug-taking lifestyle become the

central life interest and the primary determinant of all social relations. The drug culture is, in fact, creating a psychopathic environment within families. Effective family functioning is determined not by the rules or moral values of one's sociocultural group, but by the dictates of a system of deviancy and chaos. To the extent that families experience this cultural disalignment, there is tension and potential conflict within and between families.

The impact of the drug culture is that parents have to compete with a culture that provides immediate gratification and material possessions to participants of the system. The glamor, glitter, and material possessions of the drug dealers serve as a powerful attractant, seductively enticing more and more youth to enter into the web of self-destructive behavior. The drug dealer emerges as a model of someone who has been able to create an alternative economic activity that gives him or her the material vestiges of power. In the presence of high levels of unemployment, limited educational attainment, and the adoption of a materialistic value orientation, drug dealing and drug-related activity emerge as a viable economic enterprise for urban Black youth.

In this vein, families are confronted by a phenomenon that is simultaneously aberrant, addictive, and economically viable. On the one hand, in response to economic impoverishment, participation in drug trafficking appears to be the only option for family economic viability and hence becomes reasonable and acceptable, while on the other hand, the same act of participation represents behavioral dysfunctioning and social deviancy. The conflict of values between participating in an illegal activity that also benefits the family is, in part, the basis for the expression of severe feelings of psychological stress/trauma.

The deleterious effect of the emerging drug culture impacts on the dynamics of Black families. Black families are living in a violent, unpredictable, volatile, and unsafe environment. The climate of drugs has resulted in families who are simultaneously victims and representatives of the drug lifestyle.

Within the family system the authority of the family is severely threatened when children see their parents unable to protect themselves from the organized network of drug dealers and the pervasive presence of drug activity. The high level of organization and sophistication of the drug dealers stands in stark contrast to the relative disorganization, apathy, and helplessness of the Black community. Afraid to go against such a powerful and unknown force, the families live in constant fear of the drug dealers. In effect, Black families are living in a virtual state of house arrest. Held hostage by those involved in drug-related activities, parents, in general, are unable to assert themselves in any substantial manner in order to arrest the continued deterioration of the Black community.

The stark comparison between a viable and historically stable African-American cultural orientation and the emerging drug culture underscores the

complexity yet basic simplicity of our task. Rationally, if we are to be successful in our prevention efforts in African-American communities, we must revitalize our historical cultural themes as dynamic affirmations in order to create an environment in which drug involvement is not seen as an appropriate response leading to our sense of excellence.

That, it seems to me, is the equation. How do we take our own cultural themes and use them in our prevention efforts?

In developing a cultural paradigm, there are some special features in the Black family (that is, the Black family in its own integrity, not the Black family as a creation resulting from enslavement or oppression or exploitation). The Black family has some features that we can begin to look at and talk about as we develop our own blueprint.

The organizational purpose in the Black family has been one based upon the critical and crucial placement of the children. This child-centered notion in the Black family is a historical one at which we can look. The same thing with social organization/interpersonal relationships/role relations.

The family support system features that have been traditional to our families are critical in terms of a permanent notion of prevention. The Black family does something for its product. In fact, we should recognize that family systems are a process that ends in a product. The question for us is what product we want from our family systems. It seems to me when you study the Black family in its traditional intact form—and I don't mean Mommy, Daddy, 2.5 children, a dog named Spot, and a cat named Pup, but a family that is viable in what it does in terms of its performance—you see a family providing its membership with:

- the legitimation of its being;
- codes of conduct;
- the boundaries and the parameters for it to express, explore, and experiment with different kinds of behavior;
- information and knowledge about what you do and how you do it and when you do it and who you do it with; and
- an interpretation of the concrete conditions that affect and influence our children.

These support systems, which are indigenous to a family system, would be the similar kind of support systems critical to a permanent system of prevention. The model I'm suggesting to you is that of healthy, functioning Black families, African-American families. In the real world of treatment, however, we see families that are in need of care, that are at risk.

We cannot afford to utilize the families that are weakened as models of Black families. We have to have a standard of the family.

In that backdrop, we designed a study to try to examine what are kinds of ethological, if you will, social situations are impacting on Black families today. In addition to the fact that racism still exists, oppression still exists, unemployment still exists, what are the kinds of factors that are impacting on the Black family?

We looked at this issue of drug trafficking, not because we were insightful, but because the institute that I direct is a community-based institute and the community literally directs this institute to address certain problems. We were directed by the community to look at what's happening to Black children.

Mothers and fathers were saying, "I don't understand why my child is doing these kinds of things. He's not on drugs. She's not into drugs. But why is she not doing the kinds of things that I would anticipate and expect?" In short, what cultural orientation is the child operating under?

In addition to that, the study was designed not only to look at the families (we interviewed over 200 families), but we also looked at those agencies that were designed to provide treatment to families—mental health agencies, drug treatment agencies, family services agencies that were designed and given the mandate to heal the sick. We wanted to look at what the drug trafficking, drug-related behavior was, in fact, doing to our delivery of services simultaneously with what's happening in families.

In fact, one of our most significant findings is that the overwhelming behavioral impact of drug-related behavior was family violence. Not only violence within the family, but families living within an environment of violence. And that environment of violence had a critical impact on the kinds of behavioral dynamics you were able to see within the family.

One out of every five families that we talked with had reported an experience with some violent behavior by a member of the family or by a member of their community that was related to the drug activity, what I will call from now on the drug business, because there is a business of drugs in the Black community that has its own rules and regulations and, in fact, has its own cultural framework.

Thirteen percent of the children that we talked to—we talked to both adults and children in families—indicated that they were noticing in their own family membership bizarre and strange behavior that we later were able to associate with the kinds of symptomology you see in actual drug use and abuse.

In this particular community we were interested in knowing how prevalent the drug-related activity was. We found that 64 percent of the adults that we

talked to (and we were able to generalize these data to the entire Black community in Oakland) were personally aware of drug-related activity and, in fact, had witnessed and seen drug-related activities several times per day.

In fact, as a brief anecdote, one of my daughters had her bicycle stolen and the man who stole her bicycle was bold enough to ride the bicycle back down the street in front of our house because he thought it was his. My daughter started yelling that her bike was going down the street and I went to try to find this guy to get it back.

I was just walking to the housing project, but at least three times in less than five minutes of my trek through the housing project, I was approached by young Black men asking if I was interested in buying drugs.

Now, they didn't know whether I was a narcotics cop. They didn't know whether I was a maniac. They didn't know whether I was a whatever, but the prevalence of that activity is obvious in the community.

When we looked at the consequences for children as a result of the drug business, 81 percent of the parents in the survey believed that their children were attracted to the lifestyle and material wealth of the drug dealers.

I don't know whether you all heard of Felix Mitchell back in Washington, but Felix Mitchell was the newspapers' Robin Hood and they gave a lot of attention to him being the drug kingpin of Oakland and the czar of cocaine. He was finally killed in prison over a couple of dollars, but the point is that the newspapers made him a hero for Black kids. When his funeral was conducted, there were expensive cars parked everywhere and he was drawn in an open-glass carriage with six white horses. Black kids lined up across the streets to see this man who was causing a plague on the Black community.

Image is a critical part of the emerging drug culture. We looked at that just as we looked at this issue of drug use.

We found that some 66 percent of the children we surveyed indicated themselves to be attracted to the drug lifestyle, and we projected that to Oakland's Black youth population (the average child in our study was 14½ years old, so we are talking about young teenagers). What we, in fact, are seeing is the potential for some 20,000 Black kids to see the drug lifestyle, drug wealth, drug materialism as something to emulate, something to attempt to model.

And when we asked the question of whether or not the drug dealers had any redeeming value, the children in our study also indicated that they thought the drug dealers helped their families. In actuality, that is one of the contradictions of the drug business. Given the high rates of unemployment, and the continuation of oppression in the Black community, some families literally have to turn their eye away from the fact that their child is involved in the drug business

because they benefit economically from the resources that that child is providing to the family. So it's a very difficult phenomena because on one hand it is purely pathological, and on the other hand it's an economic necessity. It's a critical issue that we have to address.

As we mentioned for table 1, we found that rather than a sense of appropriateness and a sense of excellence governing behavior, in the drug culture a major theme is "anything is permissible." So respect for elders doesn't mean anything. Respect for property doesn't mean anything. Respect for your own person doesn't mean anything.

A second theme, rather than a sense of excellence, is "to trust no one." In fact, the survival and the necessities of the drug business dictate that you operate in a value system that is based on selfishness, materialism, extreme violence, individualism, manipulation, the need and desire for immediate gratification, distrust, and the lack of family or community orientation. Ultimately one's sense of worth is equated with quantity, not quality. A young Black boy who is involved in the drug business—not drug use, but the drug culture—feels that he is somebody if he can count the number of girls he got pregnant, if he can count the number of sweatsuits he has in his closet, if he can count the money he has in his pocket, if he can count, count, count—that becomes his sense of self-worth.

So what we clearly see, and I'm going to conclude on this note, is that the emerging drug culture, like other cultural groups, has a its own general design for living and patterns for interpreting reality.

As Dr. Primm mentioned, the use of AODs is dictated within a people's culture. If we don't know what our culture is in terms of its proper role, then we cannot do that translation about the general design for living and patterns for interpreting reality. The traditional Black family's cultural orientation is being replaced with a drug culture orientation that has seized the Black community. Our children are beginning to interpret their condition radically differently from their parents' interpretation of their condition.

And so all these strategies like Just Say No don't work because the children are operating in a different cultural orientation.

When we match up the DSM-III classification of the psychopath, we see a parallelism to the values that the drug culture requires. As such, the drug culture becomes a clear and present danger in the Black community, because to do nothing about the drug culture is to allow us to breed and to continue to develop a generation of psychopaths.

And that's the fundamental danger of the drug culture. We left this research, recognizing that when you talk to those treatment agencies, the treatment agencies give the same response as the families: the doctor, if you will, was

suffering from the same malady as the patient and did not know what to do. Part of that is because much of our treatment methodology, particularly in psychology, emerges from a Western cultural framework that is not directly applicable to the experiences of Black people from our culture as well as our concrete conditions and consequently they over and over and over again fail to remediate Black problems.

So our ultimate recommendation is that if we are going to do anything about this drug trafficking, drug-related behavior, we need to establish as a demonstration project a center for Black child development and family life charged with the singular responsibility of developing culturally consistent intervention and treatment methods. We must no longer simply borrow somebody else's methodology. We have to be about the task of developing our own culturally consistent intervention and treatment methods and attempt to implement Black child development and family life training programs that are based on the left side of that schema so that our children will develop and grow up to be competent, confident, and conscious human beings.

[*After Dr. Nobles's presentation, he enlarged upon one of his points in response to questions from participants. The executive summary of the Institute's study,* The Culture of Drugs in the Black Community, *was published by the Institute for the Advanced Study of Black Family Life and Culture, Inc., P.O. Box 24739, Oakland, CA 94623, and copies of the complete study are also available from the Institute. Dr. Nobles stated that a replication of the study was being planned for the Los Angeles area.*]

Dr. Swanson: The approach of human ecology to the study of AOD use and abuse disorders begins with a foundational insight: damage to organic tissues and damage to social issues are equally a part of illnesses in general, either as a consequence or a cause. To address the problems of AOD abuse ecologically is thus to deal eventually with poverty, unemployment, economic dependence, discrimination, inadequate education, dangerous and disintegrated families, homelessness, suicide, and homicide. This paper presents data on the human surround as it shapes not only the behaviors and morbidities of AOD use and abuse, but also the particular conditions under which people most often die as a result.

The grimmest pictures of the economic and social pathologies often accompanying AOD use and abuse disorders can be seen in several environments in this country. The places that come to mind are quite dissimilar in some ways but share other important characteristics. They are commonly populated by economically disadvantaged ethnic minorities whose living conditions are increasingly desperate: the inner-city ghetto, the Native American reservation, and the Mexican border region of the Southwest, to name three.

I would like briefly to sketch and compare some of the human-ecological contours of these three sorts of places as they differentially affect mortality caused by suicide, homicide, and chronic alcoholism. As we shall see, major sources of stress—such as extreme poverty and crowded living conditions—are always harmful to some degree but do not have the same pathogenic effect in every group or in every place; much depends, in the end, on the cultural infrastructure defining accepted ways of living and on traditional approaches to overcoming difficult circumstances.

As we attend to the patterning of AOD use and abuse disorders in groups of people, it is important to begin with a broad concept of illness and its effects on humans. Insults to the body must not be seen as separate from a harmful change in a person's relation to others or from an injury to a person's reflective view of self. That is because matters of illness and health are rooted in human relations; they are conditioned by access to economic resources and power as well as to the social commodities of family, friends, a community, and a cultural tradition. These resources provide a needed sense of origin, location, and connectedness to others, but also they empower individuals with options and chances for independent growth throughout the lifespan.

When all this is absent or limited for persons in certain classes, strata, or environments, the volume of stress affecting them increases at the same time their ability to absorb it decreases. For such persons, the range of healthy responses to life's vicissitudes may be constricted by the very scarcity that makes their existence so difficult in the first place. The responses that are available under these circumstances are often maladaptive and harmful; thus, the risk for succumbing to a range of illnesses (not the least of which are those illnesses of the mind and spirit) can be expected to increase in groups with the least advantages. Moreover, persons in such environments who become chronically discontent, disoriented, or dysfunctional can hardly help *creating* more problems for themselves, more isolation, and more harmful change, to which they are then even less able to adapt.

The data presented here come from the *County Problem Indicators 1975–1980* data base National Institute on Alcohol Abuse and Alcoholism (NIAAA 1985). NIAAA compiled these county-level sociodemographic data from the 1980 census and from the National Center for Health Statistics. The chief dependent variable to be considered is an index developed by Henry Mahlin and his colleagues at NIAAA in their research on county problems associated with alcohol abuse. I think it makes sense to think of this index more broadly as "psychiatric mortality," insofar as the indexed causes of death—suicide, homicide, and so forth—are associated with a range of psychiatric disorders, not only with alcoholism. In particular, a large proportion of persons who are dangerously violent or homicidal have personality or emotional disorders and are AOD users; a significant number of them are psychotic. Persons who

commit suicide are most often severely depressed; but those with other primary disorders, ranging from schizophrenia to severe anxiety, have increased rates of suicide as well.

The first observation that might be made about these causes of death is that they tend to affect big city populations most often. We get a good picture of this by looking at mortality index percentiles for the counties containing New York, Philadelphia, Washington, DC, Los Angeles, San Francisco, Miami, Atlanta, Chicago, Boston, Detroit, Houston, and a number of other major metropolitan counties: quite simply, they are all above the 90th percentile in mortality due to these causes. That is to say, there are more deaths per capita from alcoholism, suicide, and homicide in these big city counties than in 9 out of 10 counties in the Nation.

I have selected five major urban counties—scattered in the East, West, North, and South—to demonstrate this point in more detail. Table 2 shows death rates for three of the causes that make up the composite index: alcoholic cirrhosis, suicide, and homicide. Other causes related to alcohol abuse per se are included in the index but not portrayed here. As these data show, death rates from alcoholism and homicide are much higher in big city counties than in the country as a whole; the same tends to be true of suicide, though the effect is not uniform and not as pronounced. (Mortality rates, after all, are a sort of zero-sum game; people at highest risk for suicide may die first of other causes, such as AOD abuse.) In any case, the rightmost column on the table tells the story. These five urban counties are all above the 97th percentile, relative to all U.S. counties, in the psychiatric mortality index.

Table 2. Mortality Rates* for Causes Related to Psychiatric Disorder in Five Selected Urban Cities

	Cirrhosis	Suicide	Homicide	Index**
New York	37.6	11.3	27.9	96
San Fran.	50.3	31.9	21.2	98
Wash., DC	58.8	13.0	34.9	99
Detroit	37.8	18.4	35.0	97
Atlanta	25.9	19.4	38.4	99
U.S. Total	17.8	16.0	12.4	–

*Deaths per 100,000 persons aged 15–74
**Percentile rank among all U.S. counties: alcoholism, suicide, and homicide combined

What explanations might we consider for this effect? One venerable theory says that urban living is itself unduly stressful and can lead to mental breakdown, insanity, and even death. Over 100 years ago Edward Jarvis (1855) noted that insanity tended to occur more frequently in cities than in rural areas. In the report of his Commission on Lunacy, which he entitled "Insanity and Idiocy in Massachusetts," Jarvis wrote the following:

> Insanity is then a part of the price we pay for civilization ... more opportunities and rewards for great and excessive mental action, more uncertain and hazardous employments and consequently more disappointments, more means and provocations for sensual indulgence ... more groundless hopes, and more painful struggles to achieve that which is beyond reach, or to effect the impossible.

Another early study of urban-rural differences was that of A.O. Wright (1884), who examined rates of officially identified insanity cases recorded by each State in the 1880 census. He found that Massachusetts had the highest insanity rate and that insanity tended to decrease further inland; that is, rates were lower in more recently settled States. Wright concluded that primarily young, able-bodied people went out to the frontier while the weak and demented were left behind, thus inflating the insanity rate in places like Massachusetts. (People in Texas commonly note the same phenomenon about Washington, DC.)

Yet another pioneering (if somewhat misguided) social ecologist, W.A. White (1903), noted the same pattern in the 1880 and 1890 censuses but interpreted it differently. He suggested, in line with Jarvis, that the stress of civilization caused mental illness. In his own words,

> The savage in his simplicity does not know what it is to suffer from the cares and worries which are the daily portion of the European, and it is little wonder that the latter, beset by all manner of disappointments and vexations, should more frequently break down in mind than his less gifted brother.

In the cultural history of America in general, a strongly antiurban theme can be found. The quality of 19th-century American life was carried along, at some profound level of the imagination, by romantic myths of pastoralism and pioneering; cities were a necessary evil. These myths not only shaped a number of rural utopian movements, but also inspired moral reform in the treatment of the mentally ill. It was thought that if the insane could be removed from the city's crowds and confusion and competitive frenzy—if they could be given "asylum" in the pastoral countryside—then their troubled spirits would return to health. The rural location of numerous custodial psychiatric institutions testified to this early ecological view of mental illness. Likewise, early social casework was quite explicitly intended to help people contend more effectively with the noxious urban environment.

The pioneering study of the geographic distribution of mental disorder *within* urban areas was that of Robert E. L. Faris and H. Warren Dunham (1939). They found that rates of first admission to mental hospitals for psychoses varied systematically with the social character and economic level of the Chicago census tracts that patients had inhabited prior to admission. They found generally that rates were highest in the inner city and tended to decrease in concentric zones moving out toward the suburbs. Faris and Dunham interpreted their findings in a provocative way. In line with the Chicago-school sociology of their day, they viewed the urban distribution of psychoses in light of other observations about the city as a living environment. They noted that life in the inner city was socially disorganized: people there were crowded together but isolated from family members, crime was more common, and so on. And they saw this situation as evidence that the inner-city environment was pathogenic; in short, psychiatric casualties could be either caused or triggered by the alienation and poverty of social life common in the rooming house districts of downtown Chicago.

A different theory, but not an uncomplementary one, is perhaps more popular today: the inner-urban environment ecologically selects for people who have a chronic illness such as alcoholism or schizophrenia, or who are predisposed to it. That is to say, citizens who already are chronically mentally ill drift into the inner city (and/or fail to get out) because they cannot function in other strata of society; finally, skid row is where they can survive—at least for a time.

From the point of view of these theories of urbanism, we might find it surprising to discover which State has the highest death rates in the Nation for alcoholism, suicide, and homicide. That State is New Mexico—largely a rural and sparsely populated State. The worst-off county in New Mexico, along these lines, is McKinley, a rural county in the western mountains on the Arizona border. Its death rate for alcoholism is 20 times higher than the national rate.

What is it about McKinley County? This county has something in common with a handful of other counties scattered in the Southwest and upper Midwest. All are populated almost entirely by Native Americans, and all have mortality rates due to alcoholism, suicide, and homicide that are above the 96th percentile for counties in the Nation. To demonstrate this in more detail, I have selected five Native American counties in North and South Dakota and in Wisconsin, shown in table 3.

We might pose the following question: What do the Native American counties and the big city counties have in common that might increase the risk of psychiatric mortality in both kinds of living environments? One (somewhat surprising) answer is that both tend to be crowded—though at different levels of living space. The big city counties are crowded in terms of overall population density, as measured by persons per square mile (table 4).

Table 3. Mortality Rates* for Causes Related to Psychiatric Disorder in Five Selected Native American Counties

	Cirrhosis	Suicide	Homicide	Index**
COUNTIES				
Shannon	90.6	31.3	101.9	99
Menominee	61.3	35.0	70.0	96
Sioux	185.6	41.2	48.1	99
Todd	78.7	35.4	62.9	99
Buffalo	138.1	46.0	30.7	98
U.S. Total	17.8	16.0	12.4	–

*Deaths per 100,000 persons aged 15–74
**Percentile rank among all U.S. counties: alcoholism, suicide, and homicide combined

Table 4. Rates of Urbanization, Population Density, and Crowded Housing in Five Selected Urban Cities

	Percent Population Urbanized*	Population Per Square Mile	Percent Crowded Housing**
CITIES			
New York	100.0	23,403	8.2
San Fran.	100.0	14,636	7.3
Wash. DC	100.0	10,181	8.1
Detroit	98.4	3,801	3.9
Atlanta	95.8	1,105	4.9
U.S. Total	73.7	64	4.8

*Percent of population living in incorporated areas of 2,500 inhabitants or more
**Percent of households with more than one person per room

The Native American counties, on the other hand, are very sparsely populated overall—almost completely rural—but tend to be much more crowded than most counties at the household living level—i.e., as measured by the percent of dwellings that have more than one inhabitant per room (table 5).

Another high-risk quality shared by both kinds of environments is family poverty and economic dependence. Table 6 shows that the urban counties have

Table 5. Rates of Urbanization, Population Density, and Crowded Housing in Five Selected Native American Counties

	Percent Population Urbanized*	Population Per Square Mile	Percent Crowded Housing**
COUNTIES			
Shannon	27.0	5	43.9
Menominee	0.0	9	27.2
Sioux	0.0	3	18.0
Todd	0.0	5	21.6
Buffalo	0.0	4	21.8
U.S. Total	73.7	64	4.8

*Percent of population living in incorporated areas of 2,500 inhabitants or more.
**Percent of households with more than one person per room.

Table 6. Rates of Family Poverty and Dependence in Five Selected Urban Cities

	Percent Families Below Poverty	Percent Families on Public Assistance
New York	17.2	16.2
San Fran.	10.3	12.7
Wash. DC	15.1	15.2
Detroit	11.8	15.1
Atlanta	17.5	12.5
U.S. Total	9.6	8.0

considerably higher rates than the United States overall of the percent of families living below the poverty line and those receiving public assistance.

When we turn to the Native American counties, we see that they also have very high rates of poverty and economic dependence—much higher, on the whole, than the urban counties (table 7). Moreover, the Native American counties apparently have many more poor families that are not receiving public assistance, whereas rates of family poverty in the big cities/counties tend to be at about the same level as rates of public dependence.

In some sense, we need search no further than poverty for an ecological explanation of high rates of psychiatric mortality; poverty is a strong single

Table 7. Rates of Family Poverty and Dependence in Five Selected Native American Counties

	Percent Families Below Poverty	Percent Families on Public Assistance
COUNTIES		
Shannon	43.3	31.3
Menominee	37.8	15.3
Sioux	27.6	13.8
Todd	38.9	23.2
Buffalo	38.4	19.4
U.S. Total	9.6	8.0

predictor of high rates of death due to alcoholism, suicide, and homicide in the entire national database of county problem indicators. It is important to note, however, that the unit of analysis here is properly *areas*, not individuals. This statement is not the same as saying that the conditions of being poor and on welfare place individual persons at risk for dying of causes related to mental illness, though it may well be true. Rather, we are considering ecological associations. Areas with lots of welfare mothers have high rates of alcoholic mortality; we surely cannot conclude from this datum that welfare mothers are more prone to alcoholism than anyone else. We only know that rates of poverty and alcoholic mortality tend to go together. This statement, in short, is about the social environment. What we can say is that the stress of scarcity and economic discrimination—viewed as a characteristic of the environment, either rural or urban—is broadly linked to the pathology of mental illness.

But now let us consider another example. A number of parallels that can be drawn between the Native American counties and the Mexican border counties in the lower Rio Grande Valley of Texas. For one thing, both kinds of areas are populated predominantly (65 percent to 99 percent) by members of economically disadvantaged minorities. The areas are similar in other ways as well. Table 8 reflects rates of urbanization, population density, and crowded housing in five selected counties in the Rio Grande Valley. Though there is a range of urbanization in these counties, clearly they hold in common a high prevalence of crowding at the household level, one several times higher than that of the United States as a whole.

Table 9 shows median rates for all three groups of selected counties: the big cities, the Native American areas, and the Valley region in Texas.

Compared with the big city counties, both the Native American and Rio Grande counties are low in population density, though the border counties are

Table 8. Rates of Urbanization, Population Density, and Crowded Housing in Five Selected Texas-Mexico Border Counties

	Percent Population Urbanized*	Population Per Square Mile	Percent Crowded Housing**
COUNTIES			
Webb	95.7	30	26.5
Cameron	78.9	232	23.4
Hidalgo	75.0	181	25.9
Zapata	57.8	7	17.8
Starr	45.3	22	29.4
U.S. Total	73.7	64	4.8

*Percent of population living in incorporated areas of 2,500 inhabitants or more.
**Percent of households with more than one person per room.

Table 9. Median Rates of Urbanization, Population Density, and Crowded Housing in Three Groups of Five Selected Counties

	Percent Population Urbanized*	Population Per Square Mile	Percent Crowded Housing**
COUNTIES			
Big City	100.0	10,181	7.3
Native American	0.0	5	21.8
Rio Grande	75.0	32	23.4
U.S. Total	73.7	64	4.8

*Percent of population living in incorporated areas of 2,500 inhabitants or more.
**Percent of households with more than one person per room.

considerably more urbanized than the Native American counties. But while the border counties are urbanized, they tend to be, like the Native American counties once again, very crowded at the household level—much more so than even the big cities.

Poverty and economic dependence as well are considerably more pervasive in the border counties than in the country overall, as shown in table 10. Also, we must keep in mind that these data are from 1980, the year Ronald Reagan was first elected President. This time was before the oil-related downturn in the economic fate of Texas as well as Mexico, before the severe devaluation of the

Table 10. Rates of Family Poverty and Dependence in Five Selected Texas-Mexico Border Counties

	Percent Families Below Poverty	Percent Families on Public Assistance
COUNTIES		
Webb	29.0	13.5
Cameron	26.0	13.9
Hidalgo	29.0	14.4
Zapata	23.8	15.2
Starr	45.0	20.0
U.S. Total	9.6	8.0

Table 11. Median Rates of Poverty and Dependence in Three Groups of Five Selected Counties

	Percent Families Below Poverty	Percent Families on Public Assistance
COUNTIES		
Big City	15.1	15.1
Native American	38.0	19.4
Rio Grande	29.0	14.4
U.S. Total	9.6	8.0

peso, and before the more recent waves of immigration into the border area by increasingly poor people. The argument can be made that things have gotten much worse for this region (as for others) since then.

Table 11 shows median levels on these indicators for all three selected groups of counties. In sum, poverty and economic dependence are more prevalent in all three groups than in the United States as a whole. But clearly, the Native American counties and the border counties are worse off than the big cities on this score. Moreover, the percent of families receiving public assistance in the big city counties is about the same as the percent of families below the poverty line; this occurrence is not the case in the Native American and border counties. In those areas, there appear to be many more impoverished families who are *not* receiving public assistance, as compared with the big cities.

Now comes an important question: If poverty and economic dependency are associated with high rates of psychiatric mortality (as they do tend to be nationally), what might we expect to see in the Mexican border region? Logically, we might expect the border counties to exhibit high death rates due to alcoholism, suicide, and homicide. In fact, this is *not* the case, as the data in table 12 make clear. With a couple of exceptions, these mortality rates are about the same as or lower than the U.S. total rates.

Table 12. Mortality Rates* for Causes Related to Psychiatric Disorder in Five Selected Texas-Mexico Border Counties

	Cirrhosis	Suicide	Homicide	Index**
COUNTIES				
Webb	19.8	13.7	11.4	67
Cameron	13.4	11.3	12.4	44
Hidalgo	14.0	8.8	10.5	42
Zapata	26.0	8.7	13.0	31
Starr	12.2	4.4	17.7	17
U.S. Total	17.8	16.0	12.4	–

*Deaths per 100,000 persons aged 15–74.
**Percentile rank among all U.S. counties: alcoholism, suicide, and homicide combined.

Table 13. Median Mortality Rates* for Causes Related to Psychiatric Disorder in Three Groups of Five Selected Counties

	Cirrhosis	Suicide	Homicide	Index**
COUNTIES				
Big City	37.8	18.4	34.9	98
Native American	90.6	35.0	62.9	99
Rio Grande	14.0	8.7	12.4	42
U.S. TOTAL	17.8	16.0	12.4	–

*Deaths per 100,000 persons aged 15–74.
**Percentile rank among all U.S. counties: alcoholism, suicide, and homicide combined.

Table 13 shows median rates on psychiatric mortality for the three groups of counties. Clearly, rates for the Rio Grande counties are far lower than those for the other two groups of counties.

Despite the economic problems that would seem to render the border region a high-risk environment for psychiatric disorder, there are some other significant factors that seem to protect against mortality from suicide, homicide, and alcoholism. The primary effect, I think, runs parallel to the urban versus rural character of the areas but actually has more to do with the persistence of a regulating ethnic tradition.

Table 14 shows the percentile rank of the five lower Valley counties on the composite index of death rates from suicide, alcoholism, and homicide. If we order these five counties from the highest to lowest level of psychiatric mortality, we get Webb County (containing Laredo) at the top and Starr County at the bottom. It turns out that this ranking corresponds perfectly to the ranking of these counties on urbanization—i.e., the percent of the population living in incorporated towns of at least 2,500 inhabitants. Moreover, urbanism per se is a better predictor of psychiatric mortality than is population density, although urbanism and density are highly colinear.

Table 14. Rates of Organization and Percentile Rank on Psychiatric Mortality Index for Five Selected Texas-Mexico Border Counties

	Percent Population Urbanized*	Psychiatric Mortality Index** Percentile
COUNTIES		
Webb	95.7	67
Cameron	78.9	44
Hidalgo	75.0	42
Zapata	57.8	31
Starr	45.2	17

*Percent of population living in incorporated areas of 2,500 inhabitants or more.
**Deaths per 100,000 persons aged 15–74: alcoholism, suicide, and homicide combined.

The question is why? The explanation we started with might say, quite simply, that the Mexican border counties have relatively low rates of psychiatric mortality insofar as people in the more sparsely populated counties avoid the stresses of urban living—whatever those are. Alternatively, or maybe in addition, people in these counties who *do* succumb to life-threatening psychiatric

illnesses tend to migrate out—drift toward the urban centers or back to Mexico—or perhaps tend not to migrate *into* the rural border regions in the first place.

This explanation rings true somehow. But if it makes sense, then what can we say about the Native American counties? We have seen that all of them are predominantly rural—quite a bit more so than the border region—and yet their levels of psychiatric mortality are even higher than most inner-city areas. In the Native American counties, problems are not associated with too many people per square mile, but with too many people per room in a house—which is to say poverty, not urbanization. But in the Mexican border counties, it is Starr County, the poorest and the most rural in the Valley, that has the *highest* percentage of crowded housing and the *lowest* rate of psychiatric mortality. Thus, household crowding in the border counties is strongly associated with poverty, to be sure, but not, apparently, with mortality due to alcoholism, suicide, and homicide.

Simple urban/poverty stress theories are thus unsatisfying (or at least incomplete) explanations because the extreme scarcity and crowding at the level of household living space would seem to make the Mexican border counties just as stressful as the Native American or inner-city areas. The evidence suggests, I think, that problems of poverty and economic dependence do not, in themselves and unconditionally, increase the risk for psychiatric mortality.

A better explanation is to be found, perhaps, by considering the more immediate phenomena of ways of living together as human beings, ways that may be eroded not only by urbanization but also by centuries of oppression and dispossession and ethnocide such as the Native Americans (and Blacks, too) have experienced in this country, and, the Mexican-Americans have experienced to an arguably lesser degree. These are ways of living upheld by traditional culture, family structure, and a supportive social fabric. Let us consider some relevant indicators, summarized for the three groups of counties in table 15.

Looking at the first column in table 15, we see that the big city counties and the Native American counties are much higher than the United States as a whole in the percent of single-parent families. In the border counties, however, the rate of single-parent families is lower than that in the United States as a whole. This, I would suspect, is an indicator of social disintegration and the atrophy of traditional culture in the inner-urban and Native American environs, much more so than in the Mexican border region.

Now consider column 2 in table 15. Here we see the median rates of high school incompletion in these areas. On this score, the big city counties are at the norm for the country while the Native American counties are somewhat higher; but the border counties are the worst off of the three by a wide margin. In the Native American and big city counties on the whole, only a minority of adults

Table 15. Median Percent Single-Parent, Lack of High School Education, and Females in Work Force in Three Groups of Five Selected Counties

	Single-Parent Families	Adults Without High School Education	Females in Labor Force*
COUNTIES			
Big City	36.5	31.9	60.5
Native American	34.7	42.4	57.8
Rio Grande	15.8	56.4	44.3
U.S. Total	19.5	31.8	56.8

*Percent of females over 15 who are employed or have looked for work for past 4 weeks, who are available to accept job

are without a high school education; in the border counties, 56 percent is the median percent of high school incompletion among adults. In Starr County, which is 97 percent Mexican-American and also the poorest and most rural of the Rio Grande Valley counties, 69 percent of adults are without a high school education.

Why is this significant? We normally look at high school incompletion as a measure of social, economic, and cultural impoverishment insofar as an adequate education is a basic resource for succeeding in conventional society. In the Rio Grande Valley counties, however, it indicates something else in addition: the persistence of a traditional, rural-agricultural, family-oriented Mexican culture.

Column 3 in table 15 gives median rates of female participation in the labor force for the three groups of selected counties. This column presents the median percent of females over age 15 who are employed or have looked for work during the past 4 weeks and are available to accept a job. As we might suspect, the median percent of women in the paid work force in the big city counties is the highest of the three groups—four points higher than in the United States as a whole.

What is quite remarkable, however, is that the median for the five Native American counties is actually higher than the U.S. total rate as well. That is to say, even in a region marked by unemployment on a truly massive scale, the rates of female participation in the paid labor force are at the norm for the country.

Partly this situation is because women outnumber men in the Native American counties, but also it bespeaks a desperate necessity, experienced by women with children but no male partner present, to look for paid work. If the economic picture were less bleak, this situation might suggest merely that urban values were being adopted, which is perhaps in the positive course of social progress. As it is, however, I think it also evokes a dying culture—one that continues to

disintegrate as the result of a long history of alienation, oppression, and outright ethnocide. Regarding the correspondingly high rates of alcoholism and related mortality, anthropologist Roberta Hall (1985) has noted

> Historically, Indian societies, which had developed highly structured ways of handling other problems of life, were first exposed to alcohol at a time when many other direct and indirect threats were leveled at them. This situation made it unlikely that the new drug would be integrated in a positive fashion into Indian social life. Instead, alcohol became a symbol of Euroamerican domination and Indian subjugation. What Indian people received in exchange for their way of life and the unrestricted access to the resources of the country was a drink with which to forget the past, the present, and even the future.

In contrast to the Native American counties, in sum, the Mexican border areas—especially the more rural counties—exhibit relatively low rates of family separation and lower percentages of females in the work force. At the risk of oversimplification, I think this situation suggests a traditional culture that is still somewhat intact, by comparison, though threatened to be sure by poverty, discrimination, and the vicissitudes of migration into an alien society (one that is increasingly urban, competitive, fragmented, and seemingly chaotic). The fact that this culture is threatened can be seen, I think, in the strong association between urbanism and psychiatric mortality in the five lower Valley counties. Moreover, new evidence from the Los Angeles ECA survey suggests that urban Mexican-Americans generally have as much psychiatric disorder as non-Hispanic whites (Burnam et al. 1987) though Mexican-Americans use mental health services much less (Hough et al. 1987). Regarding the effects of urban migration on traditional culture, I think a parallel phenomenon can be documented in the migration of rural Southern Blacks into northern urban areas during the past two generations.

Substantial literature suggests a complex relationship between migration and mental health. Specifically, the question has been much discussed whether migration itself is pathogenic or whether individuals who are initially at high risk for psychiatric disorder tend to migrate in disproportionate numbers. Both social causation and social selection processes need to be included in the same conceptual model. Studies of migration have shown that this sort of change requires extreme adaptive effort, can often lead to distress and illness, and is especially debilitating when it results in the individual's isolation from significant social interaction (Langner and Michael 1960; Leighton et al. 1963). However, as Murphy (1977) has aptly suggested, migration must not be treated as a unitary concept but rather as a congeries of factors relating to the culture of origin, the society of resettlement, the peculiar circumstances of the migration, and its meaning for the individual. Is migration a considered and well-prepared-for choice, a permanent move to a place where the migrant plans to

give children over to a new way of life? Or is it a forced uprooting, a being cast adrift by the destruction of the homeland, a maelstrom of economic or political oppression, even ethnocide?

Some evidence (Murphy 1977) suggests that the biggest difference between newcomers who suffer from mental disorders and those who do not is merely the presence of an enclave in which to resettle together with fellow migrants. This evidence is broadly consistent with the body of research in social support and health, which has followed Durkheim's original interest in social integration and has shown that being connected to a network of friends and family tends to mitigate the morbid effects of life stress on the individual (Dean and Lin 1977; Kaplan, Cassell, and Gore 1977). Perhaps the strongest and most provocative data along these lines were reported by Berkman and Syme (1979), showing significant differences in mortality rates for all causes based on the mere presence of social support. The protective effect of social support from a marriage partner was particularly strong for men, who incidentally are at highest risk for dying from the causes we have been considering here.

The data that I have presented on psychiatric mortality do not necessarily speak to the issue of morbidity, i.e., the prevalence of mental illness per se among the Mexican-American population in general, or among the residents of the border counties in particular. The best available studies of alcohol and other drug abuse and mental disorder among Mexican-Americans do, however, suggest that such problems—particularly alcoholism among middle-aged and younger men—are pervasive in these communities. Nevertheless, studies (e.g., Markides and Mendes de Leon 1986) also suggest that the traditional three-generation Mexican-American family provides a level of social support, especially for men and the elderly, which quite effectively protects the members of these kin networks, that is, it decreases their risk of dying from psychiatric causes such as alcohol and other drug abuse or depression.

Of course, the argument should be made that traditional culture can itself be oppressive, especially to women. A low rate of female labor force participation is a pathology of machismo, it could be said, not a sign of healthy, old-fashioned values of women staying home and caring for children. Markides and his colleagues have shown that for Mexican-American women in three-generation families going out and working for pay decreases the risk of major depression.

Social support is thus an ambiguous commodity when considered at the family level. A married male alcoholic is much more likely to stay married in a rural, traditional, male-dominated culture than in an urban culture where women have options and opportunities other than a bad marriage. Thus, the urban male alcoholic gets divorced, greatly increasing his chances of dying from alcohol abuse-related causes. The male alcoholic in a more traditional, rural

culture stays married, thus retaining a measure of protective social support, and probably staying alive longer. Is this good? For whom?

What can we say in conclusion? Perhaps the major insight of social psychiatry has been that mental illnesses not infrequently occur as both an effect and a cause of the destruction of social tissues. People who are isolated or dispossessed, or who have undergone life changes that undermine their sense of personal significance and belonging, bear an increased risk for illness in general, and illnesses of the spirit and of the mind in particular. As Kai Erikson (1976) has written

> [T]here is a sense in which separation from the familiar linkages of community is itself a form of illness. When one's communal surround disappears, and with it a feeling of belonging and identity, one tends to feel less intact personally; and one also tends to turn to illness as a way of explaining one's own discontents. This is why illness and disorder can become a way of life, a source of self-identification, a central fact of everyday existence.

I believe this statement can be true of ethnic groups and social classes as well as of individual persons. But we must remind ourselves that at the base of all groups (and group statistics) are human beings with particular characteristics and experiences, and with specific problems in living; some of which are related to using drugs, or to feeling unhappy, alone, alienated, out of touch with others, confused, and so forth. Each of these persons inhabits a world of private experience as well as a selective social and cultural world. The features of these interfacing worlds define, in large part, the course, presentation, and meaning of a person's illness. Similarly, the adaptive (and maladaptive) behavior of a person with a chronic illness affects and shapes his or her social surround throughout the life course.

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The Interaction of Health and Nutrition

Participants: Dr. James Adkins, *Moderator;* Mr. Sunday Ogbonna, *Co-moderator;* Dr. John Hathcock, Ms. Margaret Dean, Dr. Daphne Roe, Dr. Marla Reicks, and Dr. Jeannette Johnson, *Panelists;* Dr. Enid Knight, *Recorder.*

Dr. Johnson: What I am going to talk about is not so much the interaction of nutrition and alcohol and other drug use among youth but the risk for such alcohol and other drug (AOD) problem. First I will discuss the risk for alcoholism.

Not all children are at risk for alcoholism. Not everybody is at the same risk for alcoholism or for AOD problems. Although we do not know much about why some people are going to abuse drugs, we do know from the research who might. Alcoholics are more likely than nonalcoholics to have an alcoholic father, mother, sibling, or distant relative. Almost one-third of any sample of alcoholics has at least one parent who is also an alcoholic. So we know that people who grow up to become alcoholics are likely to have had some alcoholism in their family.

Children of alcoholics have a four times greater risk of alcoholism than do children of nonalcoholics. There are 28.6 million children of alcoholics in the United States, and 6.6 million are under age 18. These numbers mean that a lot of children growing up in the families of alcoholics will someday abuse alcohol themselves. No one is predestined to become an alcoholic, however. While one-third of all samples of alcoholics come from families of alcoholics, two-thirds do not. We all know people who are alcoholic or who abuse alcohol or other drugs and who have no history of this abuse in their families. Genetic factors influence the level of vulnerability to alcoholism. Genetic predispositions play a large part in later alcohol and other drug use and abuse problems.

Another very important point is that drinking differences between boys and girls are diminishing. It used to be that most alcoholics were men. Now, more and more women are becoming alcoholics.

Not only are there genetic factors associated with alcoholism but also there are environmental factors. In addition to the genes we inherited from our parents, we also live in a particular environment, and that environment has something to do with how we act and express ourselves.

Many surveys suggest that the best predictor of the drinking habits of adolescents is the attitude and behavior of their parents with regard to alcohol use. And so to answer the questions "Who is going to teach them attitudes, and who is going to teach them values, and who is going to teach them how to

cope?"—if their parents can't cope, then young people are going to learn how *not* to cope.

Phenotypic expressions of genetic and environmental factors have to do with things like having brown hair or blue eyes, being tall or short, or being fat or thin. However, the environment in which we live also has a specific relationship to how we're going to act because, as we grow over time, one phenotypic expression affects another. Genes unfold in an environmental context. Not all our genes express themselves in the first month of our life, but unfold over time, such as in the timing of the onset of puberty. Not everybody experiences puberty at the same age. If someone grows up in a typical nuclear family, the environment may change as the father, for instance, makes more money and the family moves into a different neighborhood.

The fact that environmental factors change also relates to developmental challenges. The challenges of our early life move from our home, to our school, and then on to our work environment. Thus, the complicated nature of behavior is *determined by multiple factors.* It is not just that we have one thing and another thing will happen. We have a phenotypic expression that affects another phenotypic expression at a later age; we have genetic factors that unfold at different ages; and, we have environmental factors that change throughout our lifespan.

Because of these changes, AOD abuse is a complicated phenomenon, and no one prevention strategy will be successful for all people; different strategies will be useful for different groups of people at different times in their lives. We cannot overload children with information about AOD and expect that, because they have the information, they will not use those drugs. Kids think differently at different ages. If we give children information at the wrong age—for instance, if we tell them when they are 8 all about different kinds of drugs such as marijuana, heroin, and so forth—this knowledge might say to them that it is safe to try drugs because they already know all about drugs. Perhaps if we give them information about AOD at another age, they will be less adventurous.

Next, I am going to discuss a research project I have been doing for the past several years, first at the National Institute on Alcohol Abuse and Alcoholism and now at National Institute on Drug Abuse in Baltimore. My particular interest has been children who are at risk for alcoholism and I have been looking at something called the risk and protective factors associated with alcohol abuse. Risk factors, as just noted, are those factors that predispose one toward alcoholism—that is, is a person going to drink or not, and is that person going to drink a lot? Protective factors are those that relate to the protection from AOD use by youth; that is, is a person protected from becoming an addict or alcoholic? It is not just that if a person has a certain kind of maturation, he or she will be

protected from alcohol abuse, but that, again, everything interacts with everything else.

Risk and protective factors can be divided into individual-level factors and contextual-level factors. Contextual-level factors have to do with the macroenvironment: our socioeconomic status, neighborhood, peer group, and school. Individual-level factors can be divided into psychological and biological factors.

As an example of how risk and protective factors may interact, a young girl coming from a lower socioeconomic group has a specific macroenvironment. She also has a particular rate of biological maturation that she has inherited from her parents. Some girls, for instance, start menstruating at age 9; others might not start until they are 14. Menstruation brings with it a certain kind of phenotypic maturation; thus, if she has inherited a maturation that is precocious, she starts looking like an older girl when she is 9 years old. She will also have a peer group from her lower socioeconomic environment that sees her as mature. This mature peer group is doing the things older children do, and the children in it think she is just as old as they are because she "looks" that way. As a result, she is going to be involved in a lot of activities that other 9-year-old nonprecocious prepubertal girls will probably miss. Perhaps drinking and taking drugs will be included. Thus, maturation can interact with our environment and with our peer group. These are the kinds of variables I have looked at in my research experiment.

If someone comes from a family of alcoholics, that person is at high risk. A person could be considered at low risk for alcoholism if he or she comes from a family in which there is no alcoholism. But just because someone comes from a family of AOD users doesn't mean that he or she is going to turn into an abuser because that person has to be vulnerable toward such AOD problems. Someone could be at high vulnerability or low vulnerability. High vulnerability might be precocious puberty; low vulnerability might be delayed puberty. To graph it, essentially there are four groups of children that can be plugged into four different cells (1) those who are at high risk and high vulnerability; (2) those who are at low risk and high vulnerability (e.g., children who come from families where there is no AOD use but are still vulnerable); (3) those who are at high risk and low vulnerability; and (4) those who are at low risk and low vulnerability.

Alcoholism carries with it certain risks that are not just genetic. Children born to alcoholic mothers may be born with Fetal Alcohol Syndrome. Babies with Fetal Alcohol Syndrome look very similar with a wide nose, a thin upper lip, and very small eyes. Such children may look impish but they also have specific adverse behavioral characteristics such as hyperactivity, mental retardation, or delayed growth spurts. Therefore, some children who are born to alcoholic mothers probably will not become alcoholics but are at risk for other problems.

I would next like to describe how I conducted my research. First I had to define alcoholism and recruit the parents. This task was difficult because not all alcoholic parents want their children tested. Family recruitment was especially tough. I work primarily in Bethesda, and I advertised in the newspaper. I took volunteer referrals, and, because I was at the National Institutes of Health (NIH) at the time, I worked with the NIH volunteer office. It took me 2 years to get 98 children, and I paid each about $50 to volunteer. The parents also were paid.

To do a research project of this sort and to find out about the characteristics of the children, a researcher should have a lot of time. I had to assess AOD abuse in the parents in a particular way. I had to make sure that they were truly alcoholics and not just problem drinkers, and that they had no severe psychopathological problems. I gave them a 1-hour interview to get this information. The parents were admitted if they had met the *DSM-III* criteria for alcoholism, which are the standard criteria. They were screened to make sure they did not come in drunk. I also wanted to eliminate Fetal Alcohol Syndrome babies. The offspring of these parents were males and females between the ages of 5 and 18. Demographic characteristics between the two groups of children—those of alcoholics and those of nonalcoholics—were similar.

After I interviewed the parents, I tested them on performance measures. Then I interviewed the children and gave them performance tests and about a 3-or 4-hour psychological battery. I looked at a wide variety of tests within the psychosocial adaptation and cognitive functioning area. There were some very interesting findings on cognitive functioning, which should prove useful, because male alcoholics have shown cognitive impairment, even upon recovery. The question for research is, did cognitive impairment occur *because of* the alcoholism or did it exist *prior to* the alcoholism? That question is important because we want to know about biological markers. A biological marker is something that we can find in a child who is at least 5 years old and that allows us to say, "Aha, this child has it. This child is marked in a biological way. This child is at risk of becoming an alcoholic." Because not all prevention efforts are going to work with all children, it is important to identify and help those children who are truly at risk for alcoholism. If we find a true biological marker in a child, then that is the child to whom we will give our prevention money in the hope of preventing the development of alcoholism.

Thus, I gave a whole variety of cognitive tests to address the issue of whether certain types of cognitive functioning can be used as a marker for alcoholism.

It is also noteworthy that on school competence measures children of alcoholics had lower ratings. That is, such children thought they weren't going to do as well in school as the children of nonalcoholics. The mothers in alcoholic families had the same lowered expectations. Similarly, the children of alcoholics

thought they weren't going to do well on measures of cognitive competence. Cognitive competence is different from school competence because it has to do with problem solving outside academic problems. The ratings of alcoholic mothers also reflected that their children weren't going to do as well. The correlation between the child's rating and the mother's rating was quite high and significant. They were giving me the same information about each other.

What is surprising about these data, however, is that the IQs of the children of alcoholics were not lower than those of the children of nonalcoholics. Nor were the children of alcoholics performing at different academic levels in spelling, reading, and writing. In other words, the children of alcoholics weren't doing any worse in school than the children of nonalcoholics, yet both they and their mothers *thought* they were not going to perform as well. If neither a child nor that child's parents think the child is going to do very well, why should the child bother?

To determine what was behind these findings, I also gave the children a measure of affect, or a measure of depression. What emerged was that cognitive competence had nothing to do with affect or depression in children who came from nonalcoholic families, but there *was* such a correlation in the children who came from alcoholic homes. The correlation was negative—that is, the higher their depression score, the lower their cognitive competence score. This result is significant. It means depressive symptoms may contribute to self-esteem and to the children's perception of cognitive competence.

Finally, picture a little boy who is 4 years old. This child already has a mother and a father who think certain things about him, and this child is going to grow up in a certain environment that will shape how he is going to think about himself and his performance. But the most important thing has to do with the color of this child. This child is white. All the information we have on children of alcoholics is on caucasian children; we do not know anything about children who grow up in Black families. Children who grow up in Black families have environmental stresses, challenges, and genetic predispositions of their own, different from those of white children. Research should be done on these children because we need to know whether the genetic and environmental factors interact differently in the homes where children are growing up. I cannot tell you about these children, and nobody else can either.

As to why white children and their families have been studied for alcohol abuse and not Blacks, it has been suggested that one reason is that Black families don't like to be studied that much. "We have been studied to death by white people," and that seems to be the primary turn-off. Instead, if we had more Black researchers funded to look at Black concerns, we might have some answers. Black families would respond more honestly to a Black researcher. Southern California, where I grew up, was a very heterogeneous society. But

the East Coast is not so heterogeneous. There are very homogeneous groups, and none of them really interacts or intermingles very much. A caucasian researcher in Memphis who is now working with a lot of Black families had to work with some of the Black faculty members to get access to the Black communities because she wasn't accepted into these communities as openly as her Black colleagues. This situation has a lot to do with trust and mistrust and exploitation. Thus it is absolutely essential that if we are to know anything about Black families, we need Black researchers to seek out the information. One of the things this conference might begin to develop is interest on the part of Black researchers to look precisely at these problems.

But according to Dr. Beny Primm, Blacks are entirely different from whites in terms of their responses—Black homes are different from white homes and so forth. Therefore, there is no composite alcoholic, and there is no composite drug abuser in this country. In other words, when we begin to talk about addiction, it seems as if we have a composite drug abuser—white/half Black/half Hispanic/half Native American—when that is not true, because people of different races, people from different geographical areas all respond differently to different problems.

Dr. Hathcock: To get to the nutritional aspects of interaction with a variety of substances, I want to present a brief outline of the biological relationships as I see them. Nutrition and drugs, whether they are prescription, or over-the-counter, or illicit, can be characterized into basic biological relationships. What is the drug's main effect on nutrient intake, use, and requirement?

First, there are appetite modifications. Sometimes, indeed, that is done deliberately. Amphetamines and other appetite-control drugs are used in weight loss or have been used in weight-loss programs, and certain ones are still being used. Next there is digestion impairment. Various drugs interfere with the digestion of food. There are also absorption changes, functional alterations, metabolic rate changes, and excretion rate changes. Thus, drugs affect the various ways we use nutrients.

Conversely, how do nutrition and diet affect drug metabolism and action? Certainly, some pharmacologically active substances can be found in foods and in animal feed, and not just when somebody puts the little dry weed in the brownies. Substances that occur naturally in foods may interact with a variety of medications. Certain yeasts, pickled herring, and so forth are good examples of foods containing pressor amines that may be incompatible with certain kinds of drugs and may interact with them to cause hypertensive crises. Similarly, alcohol, a pharmacologically active drug to which many people expose themselves in large quantities, interacts with several over-the-counter drugs such as acetaminophen, a drug better known as Tylenol. Several drugs have substantial

pharmacological activities that affect our metabolism and use of, and our quantitative requirements for, a variety of nutrients.

Also, of course, there are pharmacological uses, misuses, and abuses of certain nutrients in attempts to use those substances as drugs. High intakes of vitamin A, for example, may have a transient beneficial effect on acne. Certainly, the activated forms of some vitamins, such as vitamin D, are virtually drugs, and these forms have become essential nutrients for persons with certain genetic anomalies, such as those of kidney metabolism.

As to how nutrition affects the way we handle drugs, the presence of food in the stomach and intestines can affect the absorption of a drug. The effect can be either an impairment—the most usual situation—or with a few particular drugs, an enhancement of the total absorption or at least of the rate of absorption of the drug. Some drugs bind to plasma proteins, and some nutrients affect the binding of these particular drugs and, therefore, the net potency of these drugs. Detoxification rate changes are especially affected by nutrient deficiencies. To a certain extent, high protein intakes have been shown in human studies to increase the rate at which various drugs are metabolized. There are also excretion rate changes. Not all of these effects occur separately but more and more of them occur together—that is, the net pharmacological impact of a certain dose depends on the sum of these changes.

There are various types of metabolic mechanisms of drug-nutrient interactions. My purpose here is simply to list the major nutrients and the major kinds of drugs that are involved—the point being that both lists contain a huge variety. Among the nutrients that are susceptible to impaired digestion are proteins, lipids, iron, B-12, folacin, and carotenes; among the drugs accomplishing this are antacids, laxatives, analgesics, and alcohol. Several drugs—among them alcohol, laxatives, and acetaminophen—appear on more than one list. These drugs, which are widely consumed, have a variety of nutritional interactions.

What we know about drug-nutrient interactions, then, mainly relates to over-the-counter drugs, prescription medications, and alcohol. We know very little about how illicit drugs interact with nutrition. We do know they are anorexic, but the question of whether there are other, more specific antinutritional effects of illicit drugs has barely been explored, if at all.

Finally, I want to point out the problems with some high nutrient intakes. High intakes of vitamin A, for example, have been implicated as being possibly hazardous to the developing embryo in the early stages of pregnancy. There is also a good possibility that exposure to other drugs such as alcohol or barbiturates at the same time that there is exposure to or excess consumption of vitamin A by the pregnant woman may increase the likelihood of some adverse outcome—that is, a birth defect.

Dr. Roe: This discussion concerns two interrelated topics: the effect of health factors in determining AOD use and, conversely, the effect of such AOD use on health and on nutritional status.

Much has been said about the kinds of environmental and social factors that determine AOD use. My emphasis is on alcohol abuse among schoolchildren. Some of my statistics come generally from the Nation; some come from upstate New York cities.

Alcohol consumption often begins early in life, before kids enter high school, thus, nationwide, there is a high prevalence of alcohol abuse by both Blacks and whites by the time the kids are in high school and when they become high school seniors, a large number report excessive drinking. In inner-city schools, more than 40 percent drink by grade seven; in Rochester, NY, the figure is about 45 percent. In fact, alcohol consumption is the most common juvenile AOD use problem in New York State, particularly in the upstate counties. Moreover, alcohol is also a gateway drug—a drug, in other words, that establishes the precursor habit for other types of drug use.

The health and nutritional concerns involved in alcohol use by youth are linked to both the reasons for their drinking, which I'll discuss later, and the effects of their drinking on others, including their infants. Regarding the first set of concerns, adolescent drinking is associated with other negative health behaviors. These behaviors include smoking, other kinds of AOD use, and in some populations, particularly in the West, abnormal food behaviors, including anorexia and bulimia.

For instance, links exist between AOD use and malnutrition particular to youth. Drugs including alcohol, tobacco, amphetamines, and cocaine all pharmacologically suppress appetite and therefore lead to a marked decrease in food intake. This point is crucial to remember. But alcohol, over and above this, causes malnutrition not only because it has adverse effects on appetite, but also because it can cause malabsorption and impair the use of nutrients. To put this matter in other terms, the nutrient requirements of young drinkers, or of drinkers of any age, are different from those of nondrinkers or occasional drinkers.

Young drinkers are often concerned with social acceptance, with escape from situational problems, and with respite from stress. They are not concerned with developing good health and eating habits. It is easy to tell them what to do but will they listen? I think usually not. And here I want to emphasize two points.

The first deals with the question of respite drug use—particularly, of course, respite alcohol use. Young people soon come to recognize, even perhaps before addiction but certainly with addiction, that the drinking or the taking of alcohol

is a way to deal with circumstances. One drinks or takes other drugs before having to face a particular situation.

The second point is that alcohol is a gateway drug, and adolescent drinkers are not only more likely to use drugs, which are narcotics, but may also be more likely to misuse over-the-counter drugs, especially those used to achieve weight loss. These drugs include amphetamines, which are used in the form of speed. Adolescent drinkers are also more likely to misuse drugs prescribed for others—again, including appetite suppressants. In addition, adolescent drinkers are more likely than nondrinkers to be smokers, which means the subsequent immediate risk of appetite reduction and malnutrition as well as the long-term risk of heart disease and cancer is increased. Finally, adolescent drinkers are more likely to be introduced to illegal drugs, which impose risks not only of addiction and infection, but also of malnutrition and early death. Intravenous drug use, for example, leads to the risk not only of AIDS, but also of other infections that are catabolic diseases—diseases of tissue breakdown—that, again, affect nutritional status.

Another important area is the link between depression and drug use, and particularly the link between precursor depression and drinking. I would like to emphasize here that the depression that I am talking about is only, in part, situational depression—for example, situational feelings of hopelessness, especially in Black communities. I would also emphasize that depression in the psychiatric sense, which may be psychotic or nonpsychotic, is also a precursor of drinking.

And we must not forget that these drugs cost money. For emancipated minors who use alcohol and other drugs, their food budgets will be taken up by their drug use.

Finally, I want to discuss another topic that certainly relates to our responsibilities: how do kids—or anyone else—obtain drugs? Often their introduction to drugs comes because either they have been prescribed a therapeutic drug containing an addictive drug such as alcohol, or the therapeutic drug has been prescribed to another family or household member, and the kids have consumed it. I refer not only to amphetamines but also to other drugs that are used—both sedatives and stimulants. We should not forget this kind of access in our educational programs or in other programs that are developed to combat AOD use by youth.

Dr. Reicks: This paper presents some specific research results on drug-nutrient interactions. It is important to realize that there are potentially adverse consequences from the nutritional compromise caused by the abuse of prescription or over-the-counter medications. We at the Food and Drug Administration (FDA) are conducting research that examines the effects of sulfur

amino acid nutrition on drug disposition. The drug we have chosen for use in our system is acetaminophen.

Before presenting the results of my research, I would like to give some background information on acetaminophen. Some common formulations that contain acetaminophen are listed in table 1. It is a common nonprescription drug that has been available for clinical use since the mid-1950s. At the time of the first Tylenol/cyanide tampering incidents in 1982, Tylenol accounted for 35 percent of all over-the-counter analgesics marketed. In general, it acts to relieve mild to moderate pain, and it also acts as an antipyretic (agent to reduce fever). Some indications for the use of acetaminophen are listed in table 2. Its advantage over aspirin is that it does not cause stomach bleeding or irritation; therefore, it may be useful for persons who cannot tolerate aspirin.

Table 1. Formulations Containing Acetaminophen

Anacin 3	Dristan Advanced Formula
Midol PMS	Extra Strength Excedrin
Panadol	Extra Strength Sine-Aid
Comtrex	Co-Tylenol Cold Medication
Congespirin	Tylenol
Datril Extra Strength	

Table 2. Indications

Antipyretic action: reduce fever	
Analgesic relief for pain of—	
headache	minor arthritis pain
colds or flu	toothaches
sinusitis	teething
muscle aches	immunizations
earaches	tonsillectomy
bursitis	menstrual discomfort

The metabolism of acetaminophen in the liver occurs in three primary ways (table 3). When taken in recommended dosages, most of the drug is conjugated by either glucuronic acid (60 percent) or sulfate (30 percent), and a small

proportion is bioactivated to a reactive metabolic with subsequent glutathione conjugation (5–10 percent). "Conjugation" means the union or coupling of two substances in the body. Because of this coupling, the drug can then be safely excreted in the urine.

Table 3. Major Pathways of Acetaminophen Disposition

1. Glucuronic acid conjugation	~60 percent
2. Sulfate conjugation	~30 percent
3. Bioactivation to a reactive metabolite with subsequent glutathione conjugation	~5–10 percent

When the drug is taken in higher-than-recommended dosages, more of it is bioactivated by way of the third pathway, which can then cause liver damage in the form of liver cell death or necrosis unless it is coupled with glutathione. Glutathione is a sulfur-containing amino acid compound that is responsible for protecting the liver from toxicant injury. It is present in nearly all living cells, but it has a very high concentration in the liver. Significant liver damage is not seen until the liver has been depleted of glutathione to about 20 percent to 30 percent of normal. Therefore, glutathione is responsible for the safety of therapeutic recommended doses of acetaminophen.

Previously, it was thought that almost all incidences of acetaminophen-related injury were from large single toxic overdoses. In more than 95 percent of these cases, the overdose has been due to a suicide attempt. Recently, however, there has been some concern about the safety of long-term therapeutic use of acetaminophen, especially in people who are more susceptible to acetaminophen-related liver injury.

The likelihood of liver injury because of acetaminophen depends on various factors (table 4). The first factor is the total quantity ingested. The dose that might be toxic will vary for different people. In some, a toxic dose may be 15 grams or more while for a smaller percent of the population, a 6-gram dose (12 full strength Tylenol tablets) could cause liver injury. The second factor is the blood level achieved, which depends on the rate at which the stomach empties. The third factor is the rate of disposition. The fourth factor is the level of glutathione stores. A limited food intake or fasting decreases the amount of liver glutathione present. The fifth factor is the activity of the bioactivation pathway. Several behaviors including chronic alcohol consumption and

Table 4. Factors Determining Likelihood of Liver Damage

1. Total quantity ingested
2. Blood level achieved
3. Rate of disposition
4. Level of glutathione stores
5. Activity of bioactivation pathway

phenobarbital intake are known to increase this activity. Therefore, smaller total doses in people who are more susceptible could lead to liver damage.

Some clinical observations suggest an increased susceptibility to acetaminophen in alcoholics. There are reports of some alcoholics who have sustained liver cell damage after administration of acetaminophen for periods ranging from 1 day to several weeks. Malnutrition may also be prevalent because of the lifestyle of the alcoholic patient. The conditions of most persons who take analgesics and antipyretics regularly should be monitored at intervals for liver injury.

The response to acetaminophen within population groups varies greatly because of differences in detoxification pathways in different individuals and the effects of various drugs. Drugs that affect the response to acetaminophen are listed in table 5. Some drugs may increase toxicity whereas caffeine given immediately after acetaminophen tends to decrease toxicity.

Table 5. Some Drugs That Affect Response to Acetaminophen in Experimental Animals

Drug	Effect
Morphine, Dicumarol, Chloramphenicol, Tetracycline	Inhibits glucuronic acid conjugation and therefore tends to increase toxicity
Cimetidine	Less necrosis, increased survival
Propylthiouracil	Prevents glutathione depletion
Phenobarbital	Increases toxicity
Caffeine	Immediately after acetaminophen decreases toxicity

The incorporation of methionine, a sulfur-containing amino acid, into acetaminophen tablets has been proposed as a tool to reduce acetaminophen toxicity. Several studies have shown that this practice does not change the effectiveness of the analgesic and the way it is metabolized. Drug metabolism reactions instead depend on the nutrient supply of the body. For disposition of acetaminophen, the body sulfur-containing amino acid stores and the supply of glutathione are critical.

Sulfur-containing components in the body are listed in table 6. Most of the sulfur present in the animal body is derived from the sulfur-containing amino acids, methionine and cysteine. Amino acids are building blocks of protein that are joined together in chains by peptide links to form proteins. On the average, 20 different amino acids occur in proteins, and the amino acid composition of each protein varies greatly. Because of this occurrence, dietary proteins vary widely in their ability to support growth and life in laboratory animals.

Table 6. Some Sulfur-Containing Components of the Body

Insulin
Keratin of hair
Heparin
Cartilage—chondroitin sulfate
Thiamin and biotin
Bile acid—taurocholic acid
Glutathione
Enzyme systems utilizing coenzyme A

Some amino acids are indispensable for adults because the body cannot make them and must obtain them from the diet. For example, the body can make cysteine from methionine, but it cannot make methionine from cysteine. Therefore, methionine is an essential amino acid.

The major metabolic functions of methionine (fig. 1) are its (1) use for protein synthesis; (2) conversion to S-adenosylmethionine, which is used for methylation reactions; and (3) donation of its sulfur to form cysteine, which then is used for glutathione formation for drug conjugations, or is sulf-oxidized to sulfate, which is also used for drug conjugations.

Protein quality can be classified according to reference amino acid patterns (table 7). A standard pattern is given the value of 100, and patterns of other proteins are compared with this value. The pattern of essential amino acid

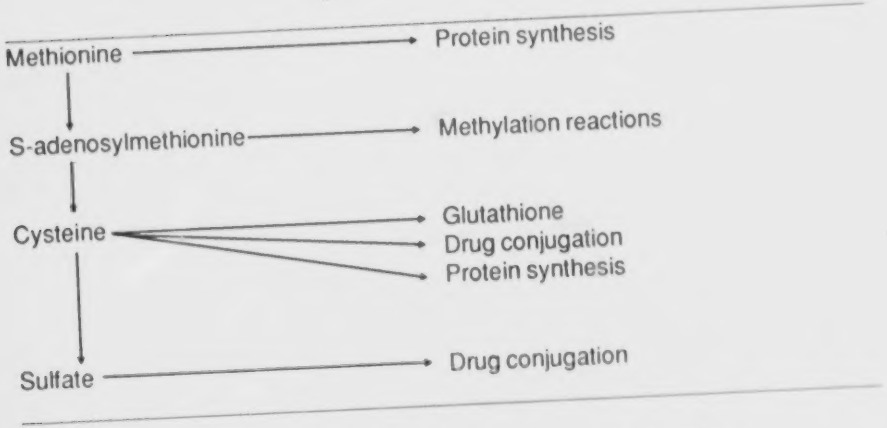

Figure 1. Major Metabolic Functions of Methionine

Table 7. Reference Amino Acid Patterns

Essential amino acid	Whole egg	Isolated Soy protein (mg/g nitrogen)	FAO/WHO 1973*
Total sulfur amino acids	355	120	220
Isoleucine	340	290	250
Leucine	540	500	440
Lysine	440	410	340
Total aromatic amino acids	580	560	380
Threonine	294	250	250
Tryptophan	106	60	60
Valine	410	290	310
Total essential amino acids	3,060	2,480	2,215

*Food and Agricultural Organization/WHO, 1973 reprinted with permission.

occurrence is compared with the standard pattern, and the protein is given a rating. The amino acid with the lowest percentage of the standard pattern is considered to be limiting the use of the protein. In most common foods, lysine, methionine and cysteine (the sulfur-containing amino acids), and tryptophan are limiting. Most animal proteins contain useful amounts of methionine, but

isolated soy protein is generally limited in sulfur amino acids. In contrast, the methionine and cysteine content of meat, milk, and egg protein is higher, in general, than a vegetable protein such as wheat flour. The methionine and cysteine requirement of an infant is much higher than that of an adult because of the requirement for growth.

The important thing to realize from this background information is that good, high-quality protein sources are needed. If they are not available or consumed by the alcoholic, the elderly, or persons dieting for weight loss, the ability to provide sulfur compounds for drug conjugation may be compromised.

To summarize this background information, the following population subgroups may be most susceptible to hazards associated with prolonged acetaminophen ingestion: (1) chronic alcoholics; (2) elderly persons because surveys show they take more nonprescription drugs and have more medical problems associated with an inadequate diet; and (3) malnourished persons.

Table 8 lists functions of sulfur-containing amino acids. The disposition of acetaminophen is affected by the body's supply of sulfur amino acids, but acetaminophen can also alter the body's stores of these amino acids. Therefore, if acetaminophen is added to the diet of laboratory animals, the need for methionine could be expected to increase to provide reserves both for the usual metabolic functions and for drug conjugations.

Table 8. Some Functions of Sulfur-Containing Amino Acids

Amino Acid	Precursor	Role
Cysteine	Glutathione	Drug conjugation
		Oxidation/Reduction
		Amino acid transport
	Taurocholic Acid	Fat absorption
Methionine	S-adenosylmethionine	Methylation reactions

We tested this hypothesis by feeding Swiss Webster weanling male mice diets containing various levels of acetaminophen, with methionine provided at the requirement, or at twice the requirement level for 2 weeks (table 9). The effects of this treatment on body weight are given in table 10. The percentage of dietary acetaminophen increases from 0 percent to 0.8 percent and the methionine percentage is either 0.5 percent (requirement level) or 1.0 percent (twice requirement level) of the diet. After 2 weeks, final body weight gain decreased

Table 9. Study Design

Species: Swiss Webster mice
Age and Sex: weanling, male
Diet Treatment: Diet contained 0.0, 0.3, 0.5, or 0.8 percent ACAP with methionine provided at the requirement level or at twice the requirement level
Duration: 2 weeks

Table 10. Effects of ACAP on Body Weight Change

ACAP	Met	Final BW	Food Consumption	
Percent	Percent	g	g/d	N
0.0	0.5	23.7 ± 2.1^{a}	4.2	6
0.3	0.5	20.2 ± 1.5^{b}	4.1	6
0.5	0.5	15.5 ± 1.6^{c}	3.5	6
0.8	0.5	9.6 ± 1.8^{d}	2.5	5
0.0	1.0	$22.0 \pm 1.8^{a,b}$	4.5	6
0.3	1.0	$21.8 \pm 1.5^{a,b}$	3.9	6
0.5	1.0	20.8 ± 1.8^{b}	4.2	6
0.8	1.0	20.4 ± 0.9^{b}	3.5	5

Values are means ± SD. Values without common superscript letters are significantly different ($p < 0.05$).

drastically in the animals that were given methionine at the 0.5 percent requirement level. When methionine was given at twice the requirement level, there was only a slight reduction in weight gain.

Food consumption was decreased in the groups that received 0.5 percent methionine (table 10). The efficiency of food use (table 11) was also decreased, as was the body weight gain. This decrease was not observed in the groups getting twice the methionine requirement level.

Liver glutathione levels (table 12) were decreased in a dose-dependent manner when methionine was given at requirement. When methionine was given at twice the requirement, a decrease was not observed. Instead, there was a slight increase in glutathione levels.

Table 11. Efficiency of Food Utilization

ACAP Percent	Met Percent	(BW/grams food consumed) ×100 Percent
0.0	0.5	37.7
0.3	0.5	24.4
0.5	0.5	8.8
0.8	0.5	−19.3
0.0	1.0	25.6
0.3	1.0	31.6
0.5	1.0	26.8
0.8	1.0	27.4

Table 12. Liver Glutathione Levels

ACAP Percent	Met Percent	(umoles/g liver)	*n*
0.0	0.5	9.23 ± 0.68^{d}	6
0.3	0.5	7.86 ± 2.62^{d}	5
0.5	0.5	3.87 ± 1.56^{e}	6
0.8	0.5	1.78 ± 0.67^{f}	5
0.0	1.0	12.00 ± 1.24^{c}	6
0.3	1.0	$12.91 \pm 1.71^{b,c}$	6
0.5	1.0	$14.75 \pm 1.50^{a,b}$	5
0.8	1.0	15.22 ± 1.40^{a}	5

Values are means ± SD. Values without common superscript letters are significantly different ($p < 0.05$).

Serum enzyme level (SGPT) is used as an indication of liver damage because enzymes leak from cells that are necrotic; an increase indicates more excessive liver damage. This occurrence was seen at the highest level of acetaminophen ingestion with methionine provided at requirement level (table 13). When methionine was given at twice the requirement level, this increase was not seen.

In conclusion, the results from this study indicate the methionine given at the requirement level is not adequate to sustain growth and to protect the liver from hepatotoxicity when acetaminophen is ingested on a prolonged basis (table 14). However, the provision of dietary methionine in excess, or at twice the requirement level, prevents growth depression, depletion of hepatic

Table 13. SGPT Activity

ACAP Percent	Met Percent	Units/Liter serum	*n*
0.0	0.5	28 ± 6^{c}	6
0.3	0.5	43 ± 17^{bc}	5
0.5	0.5	59 ± 23^{b}	6
0.8	0.5	106 ± 36^{a}	5
0.0	1.0	$41 \pm 16^{b,c}$	6
0.3	1.0	$43 \pm 23^{b,c}$	6
0.5	1.0	$40 \pm 17^{b,c}$	5
0.8	1.0	$36 \pm 24^{b,c}$	5

Values are means ± SD. Values without common superscript letters are significantly different ($p < 0.05$).

Table 14. Conclusions

A. Methionine, present in the diet at the requirement level (0.5 percent), was not adequate to sustain growth and to protect the liver from hepatotoxicity caused by prolonged ingestion of ACAP.
B. The provision of dietary methionine in excess of the requirement level prevents growth depression, depletion of hepatic GSH, and hepatotoxicity associated in prolonged ingestion of toxic levels of ACAP.
C. These results support the hypothesis that the requirement of weanling mice for sulfur-containing amino acids for growth and for drug detoxification is increased by prolonged ingestion of ACAP.

glutathione (GSH), and hepatotoxicity observed when methionine is provided at the requirement level. These results support the hypothesis that the requirement of weanling mice for sulfur-containing amino acids for both growth and drug detoxification is increased when acetaminophen is ingested for a prolonged time.

International Dimensions of Drug Trafficking

Participants: Dr. Linus Hoskins, *Moderator;* Ms. Shirlie Gibson, *Co-moderator;* Mr. Alan G. Ringgold, Dr. Manuel Gallardo, and Mr. DeSanctis, *Panelists;* Dr. Elizabeth Brabble, *Recorder.*

Mr. Ringgold: As one of the few people in the Federal Government who works for one agency but is assigned to assist a second, I have two things I want to discuss here. First is the Federal effort in the narcotics world, primarily that of the Federal Bureau of Investigation (FBI), because, in essence, that is my job. The FBI's national strategy on drug enforcement is a fairly new animal, which sort of mirrors what the Federal Government as a whole is moving toward. I then want to discuss my own personal specialty: dealing with international money laundering.

There are 33 agencies and 11 cabinet-level positions in the Federal Government involved in narcotics enforcement. The Drug Enforcement Administration (DEA) is the principal Federal agency in the fight against narcotics. In 1982 the President granted the FBI concurrent jurisdiction in narcotics with DEA. Concurrent jurisdiction means that we have the power to enforce the same laws as DEA; it is, in effect, a mandate to address a portion of our manpower toward the trafficking of narcotics.

The FBI has 9,300 agents, with approximately 1,000 involved in drug enforcement. That is really quite a large percentage—around 11 percent—and we are budgeted for around 7 percent. Thus, we have assigned a lot of extra manpower to this problem because we believe it to be a worthwhile target.

We realize, however, that with 1,000 agents we are not going to make much of a dent in the overwhelming narcotics problem unless we do what we do best: target major organizations only. We do not see our job as busting the street corner pusher. We see our job as going after the major cartels. We see as our focus the Colombians, the Sicilians, and the big organizations that deal primarily in cocaine and heroin.

Thus, we have put together the FBI's national strategy on the enforcement of narcotics laws. According to this strategy, we try to reduce the incidence of drug trafficking and other illegal activities that drug traffickers generate in America through investigations conducted on a systematic, coordinated, and sustained basis. Our ultimate objective is to neutralize heroin and cocaine distribution networks and seize illegal profits through forfeiture proceedings. We implement our strategy by attacking major drug trafficking groups nationwide. We are located in every major city in the country, and we have a phenomenal communication network among those cities. This strategy enables us to address criminal activity on an organizational basis. We concentrate our

investigative resources in those areas of the country that are identified as major centers for organizations involved in importing and distributing heroin and cocaine. With heroin, we have identified New York City as the principal importation point and consider such cities as Washington, DC, the second level. Thus, we concentrate activity requiring the most manpower and the most effort in New York City and, to a lesser extent, in Washington. With cocaine, on the other hand, the major importation centers are Miami, New York, and Los Angeles. Therefore, again, we concentrate most of our agent manpower in those areas and, to a lesser extent, in the areas we would characterize as secondary distribution points.

As I said, we have 1,000 agents. A force of that size dissipates very quickly, however, against an opponent that is as major as the drug industry.

Given our limitations in manpower and resources, then, we devote a lot of time to assisting other Federal, State, and local agencies in their battles against drugs. We do that by training police officers, by participating in local investigations, and, in some cases, by contributing financially to those investigations. This last action we can do, as I will explain later, through Federal forfeiture proceedings.

We also make a concerted effort to expand our intelligence base on drug traffickers. DEA has a phenomenal drug trafficker intelligence base. Ours also is all-encompassing but contains far fewer items of information. However, ours is growing and expanding, and the two agencies share data bases regularly.

Along with the DEA, we also assist in identifying trends and in making projections of where we are going to go next. Which city will be the next center of importation for heroin? Which city will be the next important location for us to place our manpower?

We have traditionally had a very high profile in the fight against the Sicilian Mafia. We long ago identified the organization as a major criminal problem, and we currently expend considerable resources on them. They command a very sophisticated importing network of heroin, which comes from Turkey and Pakistan, through Sicily, into New York City. It was my personal pleasure to be involved in the Pizza Connection case from its inception to its conclusion in Washington as well as in Switzerland. That, to me, was a good example of how the FBI and the DEA can communicate with each other either nationwide or worldwide and sustain long, diligent investigations.

In addition, we pursue Mexican drug organizations dealing in Mexican heroin, which affects the Southwest and the Chicago area.

We pursue major national outlaw motorcycle gangs, whose people are highly involved in drugs, especially amphetamines. Although a substantial number of

the undercover operations we have pursued against the motorcycle gangs through the years have not necessarily been oriented toward drugs, we feel these gangs are worthy of our attention.

And we pay appropriate attention to Asian organized crime groups, many of which are involved in the importation of heroin. In fact, we find these groups gaining in stature in certain areas of the country, and a look at New York City or at other major cities that have ethnic neighborhoods shows that law enforcement has had little success in these areas.

Then, finally, we pursue the other major drug-trafficking groups. For example, a number of graduates from Michigan State University from the late 1960s and early 1970s went into business together. They put together a phenomenal cocaine-importing ring involving millions of dollars a year. We feel that group merits our focused attention.

Unfortunately, the current situation is grim. One of the most sobering experiences I have had since recently returning to Washington has been participating in meetings of the National Drug Policy Board. This Board was put together by the Reagan administration as a means of focusing law enforcement attention on narcotics once again. At the last count, it included 33 committees and subcommittees. There are intelligence committees, finance committees, policy committees, prosecuting committees, and so forth, working diligently to come up with guidelines and to identify unified directions.

As to the drugs themselves, the figures, which I believe come from the State Department, are as follows. From 1982 to 1985, there was a 4 percent decrease in consumption of marijuana, while from 1984 to 1985, cocaine-related hospital emergencies showed a 24 percent increase. Worldwide production of cocaine hydrochloride rose 66 percent from the beginning of 1985 to the end of 1986, which is incredible. Removal of clandestine laboratories, primarily by the DEA, totaled 545 in 1986 and continues to show a substantial rise every year. And the purity of heroin—primarily Pakistani and Turkish heroin coming in through Sicily—has risen from 5.3 percent in 1985 to 6.1 percent in 1986.

Couple that with the price, for instance, of cocaine, which has dropped dramatically in the past couple of years because of the drug's availability. Right now, one can reportedly buy cocaine in New York City for approximately $16,000 a kilo, and in Miami for about $11,000 a kilo, which is peanuts compared with what it used to be.

Why do people deal in drugs? Obviously there is a consumer group out there for the drugs. But the bottom line is that the dealers deal because it makes them lots of money. This field is the most money-saturated imaginable.

For example, there is an organization of young entrepreneurs associated with the boat-racing industry. During the period from 1982 to 1987, about five or six of these fellows, all about 41 or 42 years old, arranged for a freighter-load of marijuana to be imported into the United States. Besides these major people, numerous shippers, offloaders, boat drivers, truck drivers, and other participants were involved. For the past 7 years, these five or six people have grossed $20 million. Consider: Is $20 million for one freighter-load, divided six ways, worth your while?

The Pizza Connection case mentioned earlier involved the importation of Turkish heroin. People would come to the money launderer daily with boxes of money. At one point, one of our informants had so much money in his safe that we had to buy him a bigger safe, which itself became so full of money that it was in danger of falling through the floor in a Manhattan skyscraper. But there was nowhere else to put the money.

There is so much money that money-counting machines, although basically expensive, have become incredibly necessary items for drug traffickers. We have seen places where 15 money-counting machines were operating at the same time.

Among the things that DEA does a lot of, as do we, are searches based on surveillances. We see places where boxes of money are being carried in, and, instead of getting a warrant from a judge, we go up and knock on the door and say, "Hi. We are with the FBI. Would you mind if we search your house?" "Why sure," they answer, "I see no reason you can't." So we search the house and find millions of dollars. "Is this your money?" we ask. "No, sir. I've never seen that money," they respond. "Whose money is it?" we ask. "I have no idea, sir," they say. "I'm just visiting for the afternoon." "Well, do you mind if we take it?" we ask. "Please do," they say. We take lots of money that way and they do not even care. It is just a cost of doing business.

For another example, it is fairly well known at this point that the Miami Federal Reserve Bank in the past several years has been the only Federal Reserve district showing a surplus. Most of the money coming through that Federal Reserve Bank will test positive for cocaine.

At this point, I want to discuss money laundering. Money laundering basically is the taking of money and changing its character to give it the appearance of legitimate gain.

To explain how it works, let me return to the drug dealer here on the street corner in Washington, who is making $1,000 a week dealing cocaine. That $1,000 is not too serious a problem for him, but he goes back to somebody else, and the next-level dealer is probably making $15,000 a week. That is a problem for him. It is a problem because he cannot use that money. He cannot buy a

Cadillac every month. He cannot buy a big house, because the Internal Revenue Service (IRS) eventually is going to show up at his door and ask about the money. So he has to try to show that money as legitimate income. How does he do that? He has got to get it out of the country, because anywhere in this country it can be scrutinized by law enforcement agencies.

Now, let us take it another step and use cocaine as a for instance. There is a guy who has $200,000 a week coming to him in small bills. He cannot put it into a safety deposit box: they do not come that big. He cannot put it in a warehouse: they are not that safe. So what is he going to do? He must find some way to get it out of the country.

At one time, dealers would put the money in a suitcase, get on an airplane, fly down to Colombia, and put it in a bank. They cannot do that easily anymore. U.S. customs officials have started to look at outgoing traffic. They also have dogs that can smell money.

To wire transfer the money out, the dealer must line up somebody to pick it up and actually transfer it. This person has to have a legitimate reason for transferring the money out, because customs regulations for transferring over $10,000 require forms to be filled out. And if forms are filled out, customs gets to look at them.

But there are many ways of laundering money. Probably the best way is "smurfing." Smurfing involves getting a whole bunch of people to buy traveler's checks or bank money orders in amounts below $10,000—say about $9,900. That gets around the $10,000 reporting law. This process takes a lot of time or people, however, because it means 9,000 "x" number of times.

Another way to launder money, and this happens very often, is to fly the money to Colombia or to Panama and then to Switzerland. The Swiss police often stop people at the airport with bagfuls of money. When told the person will deposit the money in a bank, they say, "Go ahead." They do not care. It is not against Swiss law to import cash.

Thus, it becomes the role of American law enforcement to pinpoint the people who are laundering money and notify the Swiss police that the money comes from drugs. *Then* the Swiss begin to care. The deal we have with them is that if we can point to true drug money, they will seize it and keep it. So they love being notified about drug money.

To describe how the process works in detail, let us just say you are an American cocaine dealer sitting here in Washington and you have a connection who takes your money down to Panama. That is not going to do you any good. You cannot spend the money when it is sitting in Panama, so you must get it back into the United States. But the IRS is still out there somewhere. How can

you legitimize this money so the IRS will not come after you for it? Very easy—you go to Liechtenstein and set up a corporation. You take the money from Panama to Liechtenstein by wire transfer, and once you get it to Liechtenstein, you lend it to yourself. From Liechtenstein you send the money back into the United States and you make it look as though a company over there is loaning you money. Then, as you make more profits from your drugs, you pay your company back. That is how you legitimize the money that comes in later on. It is an incredible industry.

For law enforcement agencies, however, the situation is not quite so bleak as it might appear. There *are* ways around this. The DEA and FBI have recently completed some phenomenally successful undercover operations in which we have put ourselves into the game as the player who offers to launder money. We have also convinced the Government of Panama to enact its own legislation to make narcotics money no longer eligible for deposit in Panamanian banks, and if we can prove it is drug money, they can seize it. In addition, we are trying very hard to dry up financial havens around the world. There are many of them. Every one of those little islands in the Caribbean has no source of income other than tourism and financial facilities.

In sum, we are trying very hard throughout the world, particularly in the Caribbean Basin, to make the governments understand that they are perpetuating a worldwide problem. We have a treaty with Switzerland. We are implementing treaties with other countries. We just completed one with Britain on behalf of the Cayman Islands, and we are in the process of completing one having to do with the Channel Islands. We are also working on one with Luxembourg, which is a very good haven, and we have informal agreements with Australia and Italy. Many of these countries that have bank secrecy legislation are showing a degree of cooperation with us. Finally, we have an extremely smooth working arrangement with Liechtenstein. I bring up Liechtenstein because it is the Camelot of Europe. Judges there give the U.S. law enforcement community significant assistance.

One further comment on money-laundering undercover operations is warranted here. U.S. law enforcement agencies have been criticized for providing a service to drug traffickers by laundering their money. We are doing a study on that right now to see whether it is a legitimate complaint. We do not think it is. I know of no other way to investigate the money-laundering game without becoming a player, and I do not know how to become a successful player without laundering money. If we do not launder their money, somebody else is going to do it, and we will lose our ability to observe the activity from the inside.

Dr. Gallardo: I work with the Bureau of International Narcotics Matters of the Department of State, which is designated the lead agency for international foreign policy on narcotics control. I work exclusively internationally and have

done so for the past 7 years. The people I work with are, for the most part, diplomats. Our office is headed by an assistant secretary, and our job is to develop and coordinate U.S. foreign policy with respect to narcotics control.

I stress the words "foreign policy" because our job includes but is not limited to enforcement. In effect, it uses the State Department's apparatus to get other countries and international narcotics organizations—such as the United Nations (U.N.) agencies or multilateral agencies like the Organization of American States (OAS)—to adopt policies, commit resources, and develop programs that contribute to the overall control of narcotics.

The State Department's point of view that the problem of illicit narcotics is an international one—is consistent with those of the DEA and, I imagine, the Justice Department and the FBI. There are some thoughts and concepts that flow from that core idea.

First, an international problem requires an international solution. In fact, our experience is that with rare exceptions, no country can deal effectively with a narcotics problem strictly within its own borders. An exception is China, but it took a revolution to do it, and I am not sure most countries are prepared to do that.

Second, drugs are produced in one part of the world and they are shipped to another part of the world. Money is paid for drugs in one part of the world, and it, too, is then shipped to other parts of the world. Thus, this net of interactions and transactions is truly international in focus. To try to counter it, a kind of international force has been mobilized, an effort that, unfortunately, takes a very long time to gear up. It moves extremely because we have so many laws that we have to respect, whereas the drug traffickers do not.

However, we are gradually bringing into play some machinery that is going to create barriers to traffickers. I am not sure it will stop them in total. In many parts of the world now, countries and international organizations are looking at how they can get the drug money. If they can get the money, they can keep it, and with countries strapped for resources, that becomes an extremely attractive idea. Our machinery, however, will certainly create increasingly effective barriers as it includes the whole money-laundering issue and an international effort led by the DEA and the FBI.

But, as I mentioned before, I do not think we are going to stop the drug problem with this kind of international force. The reason for that is somewhat obvious, although often overlooked. We have a tendency in the United States to perceive ourselves as the victims of this international drug cartel that is poisoning our youth. Congress shakes its head and points fingers in alarm at what the international drug-trafficking conspiracy is doing to our youth. But where does the money that is fueling this whole business come from? Drug

traffickers do not do this as a hobby. It is not fun. It is not the kind of thing one does just for the hell of it. This whole business operates on money, and the money comes from our youth. It comes from every little Tom, Dick, and Harry who decides he is going to spend $5, $10, $20, or $30 a weekend for some drugs. Those nickels and dimes fuel a tremendous international illicit drug market whose effects are so powerful that many countries perceive our little Toms, Dicks, and Harrys—our youth—as international aggressors.

Which brings me to some of the consequences of international drug traffic because it cuts both ways. Yes, of course, they are selling us drugs. They will sell us as many drugs as we can consume, as many as we are willing to buy. But on the other side, what happens with that money? There are, of course, the laundering operations but there are also far more profound consequences of this international drug market.

At the moment, we have focused a lot of attention on Nicaragua, on the contras, and on Irangate. But, in fact, the real political problem right now is not Nicaragua but farther south in Venezuela, Colombia, Ecuador, Peru, and Bolivia.

We have a situation there in which drug traffickers have so much money that they can outspend the governments. They have so much money that they are buying legislators. They are buying congresses. They are buying political systems. There is so much money that the drug traffickers who are desperate to launder billions of dollars are skewing the economy.

Suppose, for instance that an ordinary citizen wants to buy a $130,000 house to live in. If a drug trafficker wants to launder money, he can create an enterprise that will permit him later on to say he is getting income from this property, and thus he can easily pay double that amount. He does not care. That is not real money to a drug trafficker. It is all part of the cost of doing business. So he would pay $260,000 for the house and make sure he closes the ordinary buyer out of the market. That amounts to inflation, and for a small country with a fragile economy, the impact of a big spender like a drug trafficker on the economy is devastating.

By our uncontrolled use and abuse of drugs and our willingness to pay over $70 billion per year for them, we create a situation in which a peasant farmer in Bolivia, who has never had enough to eat before, suddenly finds he does not have to do anything. Coca grows like a wild plant. The farmer plants his coca; he harvests it two or three times a year; he just plucks the leaves. Then somebody shows up. The farmer does not have to haul potatoes 200 miles to the market. Instead, somebody comes right to his door and says, "May I be of service to you, sir?" Then that person will take this drug, process it, and pay the farmer. Again the farmer does not have to do anything. He is guaranteed a market. Thus,

no country or government can compete with drug traffickers. It is impossible to pay farmers enough.

As much as I regret that kind of morality, there is a certain sense to it. If I were a poor, starving farmer and somebody offered me such an opportunity, I probably would consider taking it rather than worry about the effects of the product on drug users in the United States. If that product is bad for them, tell them to stop using it. There is a certain logic on their side.

The foreign governments also benefit from the drug trafficking because they were unable to provide for the farmers. These farmers were starving because the governments do not control or even have roles in most of the area in which the peasants live. The people cannot get seeds or water or fertilizer. And when they do get crops, they often cannot get the crops to market. Then these so-called Robin Hoods, the drug traffickers, come in to help the poor peasants. Again, the peasants do not have to do any work, nor do governments have to invest anything, either. Suddenly a burden is lifted off the government's backs.

What follows, then, is a kind of honeymoon, a honeymoon with drugs on both ends. At the consumer end, there are the people who use cocaine. When they start using cocaine, they love it. There are no negatives to it. It is just one positive euphoric experience after another, until the honeymoon ends and they start to develop dependencies. And for the countries where the cocaine is produced, there is also a honeymoon phase.

Sadly, however, this honeymoon is not without a price, as the traffickers begin to make more and more money and move from being small-time crooks to being—literally—financial barons in the country. In Colombia, for example, the traffickers could afford to hire a revolutionary group called the M-19 to blow away 12 Supreme Court Justices and assault the Palace of Justice in order to steal the records that were going to be used to extradite the traffickers.

What happens when a trafficker is sentenced to jail, but is out on the streets the next day? What happens to the entire justice system when, as in Colombia, for example, people willing to become Supreme Court Justices cannot be found?

We are talking about heavy-duty violence. We are talking about the control of an economy and of a political system by a group of people who have no more morality than termites, who will literally erode, as does the termite, the structure on which it feeds without the slightest political motivation whatsoever. They are not like revolutionaries. They are not trying to change the society. They do not care. As long as they get their money, they could not care less.

Thus, one of the most profound consequences of our drug use and that of the other developed countries, in Europe especially, is the distortion of a fragile

global political structure, and I do not think we are going to correct it quickly. This process is going to be long term. The situation is going to get worse.

The big production areas are Latin America and the Andean region—Colombia, Ecuador, and Bolivia—for cocaine. Marijuana comes from the Caribbean and from Mexico. A substantial amount of our heroin comes from Mexico, although the bulk of it comes from Southwest Asia. I think Europe gets most of the Golden Triangle heroin production; however, I do not think we get much of it.

But as production and trafficking spread, drugs get diverted. These are not like oil pipelines. These are very loose human pipelines and they are full of holes. Thus, drugs begin to trickle out into the society, and it becomes very easy to sell drugs to your neighbors and to the people in your communities.

The most dramatic instance I saw of this was in Pakistan, where I began consulting about 6 years ago. The Russians had just closed down Afghanistan, and the Ayatollah Khomeini had just toppled the Shah of Iran. As a result, the traditional exporting pipelines for heroin were closed down, and trafficking was beginning right from the north through the spine of Pakistan, then south to its port. So I warned them. Floating around in the Pakistan bureaucracy is a little note to the President saying that this expert, Dr. Gallardo, said that if they did not watch out, they were going to have a heroin problem.

At the time, they had not one registered heroin addict. They had clinics so they would have known. Within a year, however, they estimated that they had about 300,000 heroin addicts. Talk about an explosion!

What I found was the old "it can't happen here" attitude, which I run into a lot. The line goes, "It can't happen here because we are too poor/ ... we are too rich/ ... we are too young/ ... we are too old/ ... we are too traditional/ ... we are too interested in pleasure/ ... we do not like pleasure/ ... we are too religious." This last excuse is a good rationale, "Good Moslems would never use heroin." Apparently a lot of bad Moslems would, though.

Pakistan is particularly fascinating because of the potential it has for a drug problem. Pakistan is a society that has suffered a lot. It is not a stable country yet. It is a new country, created only after Indian independence. Nor is it a fun country. Pakistanis are very traditional; men and women are separated, in their social lives, at a very early age. Thus, there is not a lot to do. Pakistan was a drug explosion waiting to happen.

Initially, before the new drugs were discovered, I imagine, men would go to drug dens, where they would drink tea and smoke hashish, which, in theory, Moslems are not supposed to do. They are not supposed to use things that cloud

the mind. A number of Moslems in Asia have conveniently interpreted that injunction to apply only to alcohol. Thus, it doesn't apply to hashish.

But with the introduction of new drugs, the Pakistanis would use anything. They were taking valium and crushing it. I have a picture in my office taken in the drug dens before the users got suspicious and realized what I was doing. They would squat on the floor and put drugs on these little charcoal burners, and with a little plastic straw, they would absorb the smoke. They were doing hashish, of course, but they also were doing valium and quaaludes.

When this new powder showed up and they tried it, they would say, "Boy! That's good stuff. I want some of that." There were people smoking heroin and getting addicted who did not know what they were using. They would use it for several days and then wonder what was happening when they began to withdraw. There were guys walking around in withdrawal who just did not have the foggiest idea what it could be.

Pakistanis have high levels of ignorance. The literacy rate is about 20 percent. So people are becoming addicted at unbelievable rates. The number of addicts now in Pakistan is probably close to 600,000. Heroin is all over the place, and it is very pure—between 80 percent and 90 percent. It is also relatively inexpensive. Any day laborer can afford it because it is so dirt cheap.

What I am suggesting, then, is that, as consequences of drug trafficking and of our drug consumption, we have unleashed forces in the world that we do not understand. These forces are such that as trafficking groups come in, new groups of people get addicted. Very few people in America understand our responsibility in this matter; yet in the international arenas, we tend to try to force other countries to deal with *their* responsibility. We do not go public and admit how serious we recognize our contribution to the problem to be because we just cannot afford to pay for "the entire world" to solve the problem.

In the Americas, addiction to cocaine is a problem. The Bahamas are in the middle of an unbelievable crack epidemic. A physician there has estimated that in some communities the level of crack addiction is up to 80 percent. We are seeing Nigerians getting involved in trafficking. And we are about to see the entry of African countries into the illicit drug consumption scene.

In essence, then, what we see as a result of this pattern of international drug trafficking is a politically and socially destabilizing series of effects, which, while they do not have the kind of high visibility of a war or an armed confrontation, are extremely harmful to the societies we deal with over the long term. Nothing destroys a developing country more rapidly than to have its youth become addicted. That will do it in a second, as will the situation in which a developing country, whose health care infrastructure has difficulty delivering effective primary health care for young mothers and newborn babies, suddenly has its

babies competing with junkies for treatment resources, which is what we are seeing in South America.

Thus, it is an extremely serious problem. We need to deal with healthy societies, with countries that are functional. But my greatest concern is that we as a society have not yet come to grips with our own contribution to the international drug-trafficking problem.

Mr. DeSanctis: I am a demand reduction coordinator with DEA. You ask what is a demand reduction coordinator?

There are two sides to every coin. In the case of drug use, one side involves supply. That is why we have active law enforcement efforts against the suppliers who bring drugs into our society.

On the other side is reduction through education. Historically, DEA, as well as the police, has always been on the reduction side. "Officer Friendly" programs in the schools and DEA training programs both internationally and domestically have used demand reduction specialists and techniques. DEA developed this idea along with other Federal agencies to help alleviate drug consumption within our society through education. Our younger generation must understand the dangers of alcohol and other drug use and abuse.

To achieve this, we developed a program to go into the communities and conduct seminars for high school principals, junior high school principals, elementary school principals, assistant principals, and coaches. Youngsters appreciate their coaches, and for us to get our programs to work, for us to educate the youth, we have to get the decisionmakers, the leaders, and the role models of our youth involved.

DEA has dubbed this program the Sports Drug Awareness Program, or SDAP. We get well-known athletes such as Brig Owens, Dave Winfield, Kevin Grevey, and others to conduct these seminars explaining to the administrators and coaches what they should do to guide our youth in the right direction. The message we are trying to put forth is "Just Say No to Drugs."

DEA's budget for fiscal year 1987, I believe, was $320 million. In just the 1986–1987 fiscal year, DEA seized over $380 million in assets. Why? Because before the budget was increased, we were not seizing assets—that is, the cash, the boats, the houses, the cars, and the businesses—because we did not have the wherewithal to do it. We had the law but we were not actually enforcing it. But when we started seizing assets, we realized something: once we take away their assets, they cannot come back and continue working. Before, it was easy for them either to stay in jail or to walk away from jail by posting that bond and continuing to run their organization. Now, they cannot put up a $1 million bond

and walk away from it. They cannot come back or run a cartel from jail, because nobody is going to follow them. They no longer have any money.

The drug dealers in every community within the inner city are looked up to as role models by the youngsters. Why? Because they are driving the big cars. They are flashing the big bucks. They are giving away $10, $20, $30 to the young kids to go out and get their shoes shined, to take their clothes to the cleaners, and so on. As role models, the dealers defeat the purpose of trying to make the youngsters aware of the dangers of drug use. Therefore, we are trying to take the dealers out of circulation as much as we can.

We are developing this program domestically and internationally because we realize we do not have the manpower to accomplish this task alone. We are a small outfit, only 2,800 strong. We operate in 19 field divisions around the country and in over 40 offices around the world. Thus, we cannot put all our financial resources into just this problem when we have many other problems.

But we can ask people in their communities to help because it is a societal problem. Working with communities, we can perhaps overcome the drug problem that we see today. We can go into the workplace and explain to the chief executive officers of large corporations and small businesses that if they do not take action, their productivity, their profits, and their benefits will be reduced. We can go into civic organizations like the Boy Scouts. We can hit every segment of society, all as part of the national strategy to obtain a drug-free America. And that translates into a drug-free home, a drug-free school, and a drug-free society.

Regarding the drugs coming into the country, we can try putting a 20-foot fence around the United States and segregating ourselves from the rest of the world. But there are two problems with that approach. First, the drug dealers are smart enough to realize they can build a 21-foot ladder and come back in; and second, we are a free country in a democratic society. We cannot stay within our borders and hope that the problem will go away by itself. So I ask your assistance in this effort. Actually, I am not asking you to help us. Let us help you as much as we can. The Government cannot do it alone. We need everybody's assistance. So go out, join community organizations, and take an active role in seeing that our children learn the problems associated with drug use. It is up to us, if we want to see a better society, to do what we can to teach our children the dangers associated with drugs.

If we do not do it, our legacy as parents, as educators, as uncles, aunts, brothers, and sisters will be lost down the line.

Pharmaceutical Industry: Friend or Foe?

Participants: Dr. Frank Porter, *Moderator;* Ms. Catherine Joseph, *Co-moderator;* Ms. Norma Stewart, Mr. Arthur Chalker, and Mr. Allen Duncan, *Panelists;* Ms. Lydia Savage, *Recorder.*

Ms. Stewart: My office is the Pharmaceutical and Medical Devices Control Division of the Department of Consumer and Regulatory Affairs. This division inspects, makes recommendations for licensure of, and registers those establishments and individuals who handle, manage, and use pharmaceutical, radiological, and medical device products, including alcohol and other drug (AOD) abuse treatment programs, clinics (human and animal), and all other facilities that the Department of Health and Human Services (DHHS) operates or monitors and that use the types of products just mentioned.

The Pharmaceutical and Medical Devices Control Division also registers every person who manufactures, distributes, dispenses, prescribes, conducts research on, or otherwise handles controlled drugs in the District of Columbia. Our office's inspections, investigations, and related activities allow for such persons to be monitored, thus enabling our division to play a significant role in combatting drug use among youth and abuse by adults.

The pharmaceutical industry is a large and growing industry. It consists of manufacturers, wholesalers, retailers, and other related groups, some of which employ scientists, engineers, physicians, pharmacists, and other personnel. Manufacturers, in particular, are engaged in intense competition to produce and market their pharmaceutical products. Retailers also are engaged in heavy advertising campaigns to sell these products.

Drugs that are used by youth are licitly and illicitly manufactured, and legally and illegally prescribed and dispensed. We are well aware of the hazards involved in the use and abuse of these drugs by the general public and, in particular, by our youth. A recent General Accounting Office report to Congress stated that the abuse and misuse of prescription drugs results in more injuries and deaths to Americans than do all the illegal drugs combined.

If this is the case, then clearly the pharmaceutical industry has a responsibility to combat drug use by youth and abuse by adults. It is incumbent upon those who produce and provide pharmaceuticals to educate or provide for the education of the consumer. For who in our society is more knowledgeable about drugs and thus better able to assume this task than those who produce and provide them? Today's drug use and abuse problems mandate that there be a commitment by the pharmaceutical industry to educate the American public—in particular, our youth—in regard to (1) the need for drugs—that is, the fact that they should be used for legitimate medical purposes; (2) the proper use of

drugs; and (3) the hazards of the misuse and abuse of these drugs. This is an important role and one that needs serious attention in our present so-called drug culture.

Today's society stresses freedom and individual rights. Unfortunately, many people, particularly our youth, feel they have a right to use any drug they choose. One such drug, alcohol, is a legal drug. Today's youth are bombarded with commercials promoting the use of drugs. Alcohol commercials depict adults or young adults as macho when consuming beer. Other commercials involving legal drugs depict people with the blahs or stress or who feel a headache coming on as taking a pill or tablet to prevent their maladies. Surely the message is reaching our youth. Yet this message is a mixed one when we then tell them to "just say no to drugs."

Many of today's youth are part of a nontraditional family structure, which may include two working parents, a single-parent, step-parents, or dual custody of children following divorce. Because of increased responsibilities and the pressures involved, they may experience some stress and anxiety. Drugs may appear to provide some measure of relief or pleasure for them.

Education with accurate information is a key to successful prevention. It should be used to decrease the demand for AOD that are being used by our youth.

How do we educate? The first is through ads and commercials. The second is on a personal level—that is, pharmacist or physician to patient. Pharmacists are usually the most accessible health care professionals. Thus, it is said that they play a unique and necessary role in disseminating factual knowledge about the acute and chronic effects of AOD on the individual, the family, and the community.

A third method of educating is through groups. We have professional groups, parents and concerned citizen groups, and support and peer groups. The pharmaceutical industry should provide both the professional and the economic support these groups need to function.

Apart from education, the pharmaceutical industry is also obligated to provide a drug that is needed and safe. There have been instances in which drugs have been approved by the Food and Drug Administration (FDA) and then later recalled when found to be causing serious adverse reactions. It is also known that some companies do not always present all the facts to the FDA prior to a drug's approval. I can recall, since I have been a pharmacist, such an instance with a controlled drug. Darvon compound was initially a regular prescription item and not under any controls as far as the Drug Enforcement Agency (DEA) and FDA were concerned. Many people consumed this particular drug and got high. When it was determined to be a drug of abuse, its category was changed. It is now registered or listed as a controlled substance because of its potential

for abuse, which was not previously presented. Although I have no proof that the drug company knew this face to be true, it tells me that the pharmaceutical industry has to be very careful about introducing drugs and making sure the proper research has been done in advance.

I mentioned before that the pharmaceutical industry needs to provide support, both on a professional level as far as education goes and also on an economic level to fund such education. Some companies have already engaged in certain programs. The trend now is for pharmaceutical and retail companies to support or fund groups such as parent groups or concerned citizen groups. One group, Pharmacists Against Drug Abuse, was funded by McNeill Labs. They speak to parent groups or concerned citizen groups, disseminating the kind of educational information that is needed to combat drug use among our youth.

In regard to the supply side of drugs, a commitment is needed from the pharmaceutical industry to participate in monitoring and then stemming its drug supply. Some monitoring is mandated by Federal and State drug enforcement offices, in which there are systems established for that purpose. One of them, Automation of Report and Consolidated Orders Systems (ARCOS), is part of DEA. ARCOS monitors manufacturing activities, distributions, exports, and imports of Schedule II controlled substances. Another is the Drug Abuse Warning Network (DAWN). And a more recent monitoring group is the Prescription Abuse Data Synthesis (PADS), which is very helpful on a local or State level.

Inventories are also filed biennially with DEA to monitor the supply of controlled substances. The industry must support these monitoring efforts diligently and report any diversion or dishonesty to regulatory and law enforcement personnel.

An example of monitoring on my level as a pharmacist is detecting physicians who often write prescriptions for controlled substances and seeing whether there is a legitimate need for that drug. If, in our professional view, we think there is not, we are obligated to report this judgment to the proper authorities. We are also obligated to report any fraudulent prescriptions we may run across.

The industry should push for strict enforcement of drug laws and make a commitment to education to prevent AOD use by our youth. These are important steps if we are to stem the supply of and demand for drugs that are used by our youth.

Mr. Chalker: "The Pharmaceutical Industry: Friend or Foe?" That is a challenging question, especially for someone like myself who works in the industry. People may not realize it, but perhaps we in the industry do not see anyone out there in society as victims but, instead, as beneficiaries of an industry that has grown over the years. Admittedly we have made some mistakes, and assuredly we are in business to make money. That is "the good

old American way." Every product out there has a profit margin associated with it. But more important considerations are product effectiveness and safety.

I would like to begin discussing the industry by describing the Pharmaceutical Manufacturers Association (PMA), a national trade association representing more than 100 research-based pharmaceutical companies. PMA members are located throughout the United States. They produce most of the prescription medicines used in this country and about half of the free world's supply of medicine. They will spend well over $5 billion worldwide this year to research and develop new pharmaceutical products.

A former head of the Patent Office once said that everything that should be invented had already been invented. We know that is not true in our industry. There are better medicines, better therapies to be researched and developed, and we are going to bring them to the marketplace. We are going to find the way to prevent or to cure AIDS. We are going to find, someday, a way to prevent or cure cancer. That is the business we are about. Along the way, we will make a profit.

Our industry's foes are disease and illness, mental and physical, and whatever that causes them. The mission of the research-based pharmaceutical industry is to satisfy public demand at home and around the world for medicines of the highest possible quality. To accomplish this mission we discover, develop, manufacture, and market ethical pharmaceuticals, biologicals, and diagnostic products worldwide. Our firms place special emphasis on innovation, product safety, and quality, and we are committed to supporting comprehensive research and development programs leading to products and services used in the prevention, diagnosis, cure, mitigation, and treatment of disease.

Let me emphasize that the PMA member companies are absolutely concerned about the problem of any misuse of the products we manufacture. The industry has long been active in a variety of ways to encourage the proper use of pharmaceuticals and to minimize drug problems and diversion. No responsible pharmaceutical company wishes to see its products abused or misused by those authorized to prescribe, dispense, or to take those products as patients.

No automobile has ever caused a crash or a tragedy; rather, crashes and tragedies are caused by the drivers operating that machinery. The same is true with the use of pharmaceutical products. It is the misuse or abuse of these products.

The PMA and its predecessor organizations have consistently supported constructive health care laws, policies, and controls to regulate the production and distribution of prescription drugs that are subject to abuse. The important criterion is that these regulations be based on patients' needs, the delivery of health care, and the ethical standards of the medical and pharmacy professions.

You should know our industry supported enactment of the Carson Act in 1960, which formalized the regulation of narcotics manufacturers and brought U.S. manufacturing into conformity with U.S. international treaty obligations.

The PMA was also actively involved with the congressional debate on the Drug Abuse Control Amendments of 1965, and we endorsed the Drug Abuse Prevention and Control Act of 1970, more commonly known as the Controlled Substances Act. This act recodified previous Federal statutes into a broader, more comprehensive framework. It regulates both pharmaceutical products and illicit drugs. It also provides uniform national standards for registration and criteria for scheduling, recordkeeping, reporting, security, and the dispensing of controlled substances. Thus, we created and continue to have a closed distribution system that is under a good set of regulations and laws.

The PMA also participated in developing regulations that were needed to flesh out the Controlled Substances Act. In addition, the PMA and 10 of its member companies have served on the DEA's working committee since the enactment of the Controlled Substances Act. That committee meets several times a year at DEA headquarters with compliance personnel to discuss current issues relative to DEA registrants. We are, therefore, not without communication with those who have the awesome responsibility of trying to administer and enforce the laws.

The PMA was also responsible for helping to get the Protocol on Psychotropic Substances ratified back in 1971. And we have actively participated in developing State uniform controlled substances acts, which virtually every State has adopted.

Now, what are pharmaceutical companies doing about minimizing abuse of their products? We believe our industry's major responsibilities lie in four areas. First is research. All new drugs undergo extensive pharmacological, toxicological, and clinical testing before they can be approved for marketing by the FDA. The potential depressant, stimulant, or hallucinogenic properties of new agents are closely evaluated. Under Federal law, the abuse potential of each drug product must be considered before the pharmaceutical is approved.

There are five drug control schedules. Schedule I contains drugs like heroin. These are drugs for which, at this point, no perceivable medical use or benefit can be derived. Schedule II contains drugs that are permitted to be prescribed but that carry a potential for abuse of the highest magnitude. In Schedules III, IV, and V, the potential for drug abuse and addiction liability decreases. If the drug is categorized, or scheduled, as a controlled substance, manufacturers, wholesalers, prescribers, and dispensers must apply the requisite security recordkeeping, prescribing, and dispensing controls applicable to the schedule in which the product is placed.

Providing information on the characteristics of drugs to health care professionals is the second area of responsibility for drug manufacturers. Such information concerns proper prescribing under FDA-approved labeling and is disseminated through channels such as publication of studies, sponsorship of medical seminars, and person-to-person communication by sales representatives.

Our third area of responsibility deals with security and, as mentioned previously, PMA companies have instituted comprehensive physical plant security and recordkeeping measures to comply with the regulations and minimize the potential for drug theft.

We see public education as our fourth area of responsibility. For years the PMA has conducted a highly regarded speaker service program that makes many presentations to local community groups on the subject of drug use and proper use of medicines. Together with the American School Health Association, the PMA has also developed a school curriculum guide for teaching about these subjects.

It would be a tragic thing for the youth of America, or even for those of other generations, to believe there cannot be an appropriate use or a place for prescription medicines in our society. The pharmaceutical industry has saved many lives; we have added to the productivity of our country; we have added to the very security of our country. And yet we have this horrendous drug misuse and abuse problem.

The PMA does not want to be part of the problem. We want to be part of the solution. I do not know what else has been said about it that was more poignant or profound than this, "It's really a complex problem." Most assuredly it is! The overall and total solution will probably be as complex.

A couple of final points should be made. Perhaps the time has come when we need to find a word other than "drugs" to mean pharmaceuticals or medicines and medicinal products so we protect pharmaceuticals from the negative connotation of that particular term. Then "drugs" would only mean the "bad products" or the association with illicit use.

We also need to stop *the demand* for drugs that are going to be used outside of legitimate medical reasons for which they are prescribed and dispensed; then the *supply* of drugs will never be a problem.

We also need to remember that it is *not* the drugs that cause the problem. Instead, it is the practitioners who misprescribe, who dispense drugs when they should not, and who in some way divert drugs to other than legitimate medical use. And we need to remember that those who think that reducing the supply

of legitimate drugs is going to solve the problem are not really addressing this proposed solution as comprehensively as perhaps they should.

Mr. Duncan: If the FDA is responsible for allowing abusable products on the market and if, in fact, these products are causing harm, an understandable question would be why the FDA allows that situation to exist.

The answer is that if the FDA allows drugs on the market that are medically useful but that are also extremely hazardous as far as their potential for abuse, we do this because we do not have anything else available to treat a specific symptom. If, on the other hand, we, in our wisdom, decide we are going to keep those products off the market, people who get sick or are hospitalized will not have available to them something that would provide freedom from pain or be the most appropriate treatment.

Discussion about pharmaceutical drugs that have a potential for abuse often divides along lines defined by those that have no medical use and those that do. Virtually everyone is opposed to the first type; the regulation of those is quite strenuous. I would like to discuss the other drugs—that is, those that *are* medically useful.

We do allow abusable products on the market when they have a medical use. We have various means to determine whether a drug is likely to be abused. I will not describe them here, but suffice it to say that although these tests are quite good, they are not perfect. Occasionally, a drug gets on the market that proves to be much more abusable than we expected. We are learning from our experience. I do not think that the pharmaceutical industry or the Government is sitting still. I think we have been moving forward quite a bit. We do not make many mistakes now, but we have had a few in the past.

For example, about 20 years ago, when I was a field investigator, we had fat clinics that passed out amphetamines. Millions of doses in all different colors and shapes were dispensed. Then the FDA determined that amphetamines really were not useful for losing weight beyond the first 6 to 8 weeks. So we took that indication off the labeling, and we now use about 10 to 15 percent fewer amphetamines than we used 20 years ago.

Also, about 20 years ago, barbiturates were quite effective in inducing sleep, and they were a medically useful drug. However, they not only were subject to abuse but also had a recognized safety problem. If someone took just a little too much, there could be serious consequences, including death. Then a pharmaceutical company developed a group of drugs known as benzodiazapines, which many people may know of as librium or valium. Those drugs were more effective, perhaps less abusable—we think less abusable—and certainly much safer. A person could literally take a handful and would not experience the dangerous effects of the barbiturates.

Another drug example is methaqualone. Not everyone has heard of methaqualone although it was on the market. It was a Schedule II drug, which means that it had a medical use but was very *abusable*. It was quite a good drug, actually, from a medical standpoint, but it was *very* abusable and there were other drugs that could treat the same conditions. Congress threatened to take the drug off the market by placing it in Schedule I and to withdraw the licensing application. The U.S. distributor, however, notified us that it would take that product off the market. So we have a situation in which if, for some reason, someone needed methaqualone, it would not be available.

Another group of drugs that the pharmaceutical industry has developed are called agonists/antagonists. Naloxone and naltrexone are good examples. One effect of these drugs is to counteract or block the euphoric effects of a narcotic drug. They do this by blocking what are called receptor sites and thereby preventing the opioids from acting in an abusable manner. Thus, if someone takes naloxone and then takes heroin or morphine, that person will not experience the euphoric effects that heroin or morphine normally provides because of the antagonistic effects of naloxone. In other words, that person will not experience the high.

Talwin (pentazocine hydrochloride), a pain reliever, became quite a problem when addicts learned they could shoot up by dissolving the tablet and injecting it into their arm in combination with an antihistamine. The addicts were pretty good pharmacologists. They could bring themselves up to a high, let it slack off, bring themselves back up to a high, then let it slack off again. They might run through that sequence three or four times before they actually crashed over the edge and had to stop.

The manufacturer of talwin added naloxone and called it Talwin Nx. If naloxone is ingested orally with talwin, the naloxone is inactivated in the digestive system so the user does not receive any effects from it. He or she will, however, still get the effects of the pentazocine. So as long as the drug is being used as directed for legitimate purposes, the naloxone might as well not be there.

However, if a tablet of Talwin Nx were to be crushed and injected, it would cause significant problems. When naloxone is injected parenterally, it is a very effective antagonist, and the user cannot experience the euphorgenic effects of pentazocine. In addition, he or she is very likely to develop ulcerations and experience other problems around the injection site.

Thus, the FDA and the pharmaceutical industry—mostly the pharmaceutical industry—have been quite innovative in trying to deal with some of the problems we have had.

There are many more examples. There have been articles in the newspaper suggesting that Congress is going to approve the use of heroin. It has been a

subject of discussion on numerous occasions. From a scientific and medical standpoint, heroin has to be converted by the body and metabolized into morphine before it has any effect. Actually, by taking heroin, a person is getting nothing that could not be obtained from using morphine.

Heroin has a lot of connotations, however, most of which are bad—or good, as far as addicts are concerned. It has one advantage. A very small amount of heroin—just a milliliter, a tiny fraction of a teaspoon—can be injected into a cancer patient who has emaciated, or wasted, tissue, mostly just skin and bone. That person could not take a larger volume of liquid.

We worked with a pharmaceutical manufacturer and asked, "What about making a more potent form of Dilaudid?" In fact, that is what happened. The manufacturer marketed a product called Dilaudid HP (high potency), about two-and-a-half times as potent as what was previously the most potent form. Now we have a product that is more soluble than heroin, of a higher potency than heroin, longer acting than heroin, and therefore more effective for pain than heroin. We now have a product for cancer patients who have become emaciated. They do not have to have heroin to obtain the pain relief, and heroin need not be made available for use by addicts.

There has also been a lot of talk about methadone programs, many of which can be found in the District of Columbia and in New York City. We are still working on a longer-acting methadone called LAAM, which is not yet perfected. The idea behind LAAM is that it needs to be taken only once every 3 or 4 days, so an addict does not have to take it home as often. Moreover, an addict wanting to take LAAM would not have to go by the program dispensing office as often, which would allow less opportunity for diversion of an abusable substance.

Perhaps we ought to move back a step from this to see what is actually occurring in the development of drugs—the changes that have been made in drug development—and relate it to some of the larger concerns of society. That is, we are treating some people, addicts, who really have many needs.

The attitude and the needs, social and otherwise, of the addict make the addict look for a crutch in the form of an abusable drug. Consider a person who watches television and sees an ad for extra-strength aspirin or Tylenol or something that is a stronger over-the-counter pain reliever. If that person is prone to addiction and is always going to buy and take the stronger version, he or she is exhibiting a type of behavior similar to that of an addict, except on a much lesser scale.

There are ways to relieve headaches other than taking aspirin. One can use a hot compress, have a massage, breathe in steam, and find out what is causing the headaches so as to reduce the need to take a pain reliever. But, if we all

believe that the answer is in the bottle or in a pill, or that we must go to the doctor to get something to make us feel better, then we too, may be susceptible to abusing drugs.

Systemic Factors Related to Alcohol and Other Drug Use

Participants: Dr. Ura Jean Oyemade, *Moderator;* Ms. Beverly Johnson, *Co-moderator;* Dr. Lewis King, Dr. Cheryl Sanders, Dr. Douglas G. Glasgow, and Dr. Alvis Adair, *Panelists;* Dr. Lillian Holloman, *Recorder.*

Dr. Sanders: I believe that if we are going to look toward a systemic understanding of the problem and its solutions, we are going to have to draw from a variety of disciplines and areas of study and expertise. There are, for example, the perspectives that the study and practice of religion can bring to bear upon the problem of alcohol and other drug (AOD) problems. One of the terms we use a lot at the Divinity School is "holistic perspective." By that we mean taking seriously the fact that human beings are body, spirit, and mind, not just one to the exclusion of the others; therefore, they ought to be dealt with as such.

Looking at the issue of high-risk youth in terms of AOD use, however, I have found in my own study of this problem that many people deny its moral dimension. We hear a lot about the economic factors. In fact, we probably hear more about economic factors than about anything else. But it is a faulty assumption that people do drugs because they are poor or because they do not have appropriate kinds of employment opportunities. I do not want to *deny* this assumption, but to assert that there is more to the problem because this assumption does not account for the affluent people in this society who also indulge in drugs.

Another faulty assumption is that for people who have choices, people who have resources and finances, doing drugs is not as much of a problem. The same faulty reasoning is used in analysis of the teen pregnancy problem. It bothers me that what we are primarily concerned about in teen pregnancy is having to support those children. It is a problem, true enough. But does that mean that the middle-class or upper-middle-class people do not have to worry about their sexual ethics because they can afford to pay for the consequences? Is AOD use only a problem, then, because of the social cost?

I would argue that it is not. One of the things religion and systems of religious belief can help us begin to understand is an answer to what I see as the prior question: Why is it wrong, if it is wrong, to indulge in drugs? And although that is a very simple question, the answer to it would require us to look not only at the criminal, medical, psychiatric, and psychological factors in a social dynamic analysis, but at a lot of other factors as well.

I would say that the AOD use problem has all these dimensions—political, economic, social, and so on—but it also is a manifestation of what I would call a "spiritual deficit" within our families, our neighborhoods, and our Nation as a whole, as well as within individuals. It involves the susceptibility of people to addictions of all kinds and the fact that we live in a capitalist economy that profits from people's enslavement to addictions. Addictions to cocaine and heroin and those kinds of things are put somewhat in the forefront, but I am also concerned about addictions to alcohol, nicotine, and even caffeine. Our economy is such that people can make a lot of money based on other people's addictions, particularly their enslavement to those addictions.

One other factor to mention is that I think a case could be made for the complicity of the government—and the Federal Government, in particular—in allowing the Black community to be flooded with drugs. I do not have a lot of data and statistics to offer here, but it seems that if one were to try to design a strategy for destroying the future of a particular group, it would involve making drugs available. As far as our youth are concerned, if they are susceptible to what the whole drug culture has to offer, there is a real possibility that the entire future of our community will be destroyed so that, looking ahead 50 or 100 years from now, there is no positive future. And the Government's role in how the problem has been attacked and responded to has amounted to a sort of winking at an entire generation going down the drain. Our country's founding documents contain a statement about the Government's promoting the general welfare of its people. I think the drug problem, however, reflects the opposite.

Getting back to the question, then, of why it is wrong to use drugs, it seems to me that the desire to enter into a state of euphoria has a spiritual basis to it. Thus, the question becomes is the use of so many drugs a legitimate means of acquiring a desirable state?

Before answering that, I think it should first be noted that one of the problems—and perhaps the cause of one of the breakdowns that has occurred between the Black churches and the community, historically—is that for many years, and especially in what are known as the "sanctified churches," Black churches specialized in teaching people to say "no" to everything. You couldn't do this, you couldn't do that, you couldn't go here, you couldn't go there. So people reacted against the church, "Well, they just specialize in negatives. Therefore, they're not relevant to reality." And the approach was rejected.

Now, in our time, even the Reagan administration has pushed this sort of "say no to drugs" approach. Similarly, we hear Reverend Jackson talk about "say no to drugs." But just as it was a lost message coming from the church, it seems just as much a lost message coming from these people. To expect people to say "no" because we tell them to is a bit unrealistic. What is really needed are some viable and attractive alternatives. If they only say "no," we must also show

people what they can say "yes" to. It is a much bigger problem than the alternative between the economic factors: if you get involved in drugs, you can make a lot of money; if you work at a fast food restaurant, you're going to be poor. The stakes are much higher. And one of the things the study and practice of religion can contribute to a solution is an emphasis on the wholeness of body, mind, and spirit.

Looking at the Black community in particular, however, everybody knows that AOD use and abuse are problems. More and more, we are hearing about the destructiveness of nicotine abuse in our community. The cigarette and beer manufacturers make huge sums of money available for our big affairs, parades, and other Black events, and I'm somewhat bothered by that.

But in any case, the lifestyle issues involve not only how people ingest these substances, but also how we eat and live. In Washington, DC, the statistics dealing with hypertension, cancer, heart disease, and other serious health problems whose risk factors include very poor choices in eating habits and diet reflect that it is all part of the same problem. We say, "Well, nobody eats himself to death." Well, I am not sure that is true when you look at the whole. Our addictions to certain kinds of destructive foods may kill more people than the heroin and the cocaine in the long run.

One of the things we do at my church every morning is feed homeless people. We get 200 to 300 people every morning—mostly young Black men, but also some women and older people. Basically, these are people who are down and out because of their addictions to AOD, or whatever.

When you have these people coming in such numbers, you can try to serve their needs. Some of those people are really beyond help, by which I do not mean that we should give up on them but that we should invest a lot of time and energy in helping them. Yet, it seems that the next week they are back in the same rut. We have found, though, that a close connection between this ministry and what we do with our young people exists. We can show our young people that this is what they will become if they do not make some decisions now about how they are going to live their lives—not only in terms of choosing a lifestyle, but also in terms of having aspirations and goals and of making use of whatever educational opportunities they have.

I appreciate the discussion of the problems brought about by the desegregation of schools, but for most of the young people we serve, they are in an all-Black situation. There is a real problem of motivating them to have some sort of goals or aspirations in life beyond just what ultimately becomes a dead-end street. They are in a kind of consumer mentality: a certain appearance, certain kinds of clothes, and a certain amount of money that they must have for peer acceptance and self-esteem. It is a situation in which they try to use "things" to

meet what I see as a fundamental spiritual need that cannot be met with "things" in any ultimate way.

Last, I think that a value-based educational approach is something that the churches in particular can deliver to our high-risk youth. I have observed—not so much in Washington, DC, as in some other urban areas—that Black churches are beginning to build day schools from kindergarten through 12th grade where there is a value-based emphasis, one based on Christian values. Also, most churches have some form of ministry to youth. That ministry can really make a difference in making the connections between this kind of analysis and the practical involvement with people.

Dr. Glasgow: I would like to share some thoughts regarding the structure of the Black community and related concerns that must be considered when attacking the problems of AOD use and abuse.

My experience with the drug culture began sometime in the late 1950s, when I became interested in the Mobilization for Youth project on the lower east side of Manhattan and in the Harlem Youth Opportunities project in uptown Manhattan. Drawing on that experience, a number of social activists and I sought to understand—and later develop some answers to—problems that had created major social dysfunctions in communities, especially Harlem and Bedford-Stuyvesant. These communities were predominantly Black residential areas. Harlem was more widely known for the many accomplished Blacks who came from there, but later, in the 1960s, Bedford-Stuyvesant became known as the largest Black urban living area, surpassing Harlem in both size and population.

Bedford-Stuyvesant is often characterized as a Black ghetto, different from other Black communities because of certain dominant characteristics that mark life there. In 1979, in my book *The Black Underclass,* I described Bedford-Stuyvesant as being originally contained within a 7- by 15-block area bordered by Bedford Avenue on the south, Stuyvesant on the north, Lexington on the west, and Fulton on the east. Since then, Bedford-Stuyvesant has grown, its four borders expanding some 20 to 30 additional blocks to absorb many smaller communities. Because the new communities are predominantly inhabited by people who are Black and/or who have African or Caribbean lineage, these areas are invariably included in the Bedford-Stuyvesant designation.

The term "ghetto," as applied to Bedford-Stuyvesant, is based more on the community's racial makeup than on class or other socioeconomic factors. In fact, notwithstanding the traditional explanation of Black community growth, the community's expansion was not driven only by middle-class Blacks' search for new living space outside the central core of the community. Although some Black families *did* gain income and move outside the core Bedford community into adjacent areas, the growth pattern of Bedford was also strongly influenced by

limited available housing stock (dominance of brownstones and limited tenements) in the central area.

However, even when Blacks with means moved to new adjacent communities, these areas, as noted above, shortly became relinked to the main body of Bedford-Stuyvesant. This occurrence was encouraged by two major factors: (1) the continued association of middle-class Blacks with the core Black community and its institutions—family, church, local stores with indigenous products, and so forth, and (2) the outward spread of community boundaries forced by inner-area population growth. That is, in-migration by new inhabitants and growth within already-residing families increased pressure for new space.

I have argued since 1959 and in my 1979 work on the underclass that the growth of the Black community has differed from that of the traditional non-Black community. I documented it more concretely as I began to see the varied patterns of Black community development in cities throughout the 1960s and 1970s. The fact is, while at any given point in time there may be a small community of middle- and upper-income Blacks that exists separate from the central or major body of the Black population, a pathway between these areas will soon form and link the two areas. Ultimately, the passageway and the two areas it links will form an enlarged community of Blacks. This process of community expansion is one way in which the Black community has grown. In this expansion, interconnection among different classes of Blacks remains.

More recent works critically refer to the departure of the Black middle class from the Black community, arguing that the community has basically been abandoned by its middle class and by its more stable income earners. And this is what lies at the base of the community's demise. I argue that the community has *not* been abandoned, that middle-class Blacks remain connected to and are deeply affected by Black community life but that they are overwhelmed by what they perceive to be needed to restore and maintain a durable community.

Black community life abounds with daily examples of Blacks with means participating in activities in response to community needs. Thus, we can find the most prestigious of our middle class from Baldwin Hills, Sugar Hill, and Portal Estates coming to the central city to participate in community life and help address community problems. To be sure, there is a need for even more active participation of Blacks with means and skills; however, this action alone is not enough. There must also be a changed perspective on service and help. The core objective of community activity must be to engage the residents in efforts to resolve their own problems, ultimately empowering these populations to take control of their life situations and of the forces and resources in their environment.

I do not really want to discuss in detail drugs themselves, except to say that my drug experience was with heroin users. The kids in the late 1950s used to skin pop because they thought mainlining would be too addictive. Little did they know that the addictive quality in the heroin, psychologically as well as medically, was so strong that they would eventually have to mainline to get the euphoria. Thus I agree with those who ask not how people get into drugs but how we get them out.

How do we get people out of drugs? I like to think that the family and the community and its institutions are the keys to our ability to attack the problem of abuse successfully. Writing in *The State of Black America*, Dr. Beny Primm said,

> If you really want to deal with the question of factors that will eventually lead to abuse of whatever the substance is, or lead to escapism, or lead to demobilizing the ability of people to function, when you're talking about Black Americans, the history of racism, the impact of poverty, unemployment and jobs, the proportion of attention that law enforcement gives to the Black community, drug abuse politics, and also such things as hopelessness in the ghetto life, lifestyles that reject menial or subsistence jobs and favor slick jobs like hustling, et cetera, consistently high unemployment rates, cultural and class conflicts, rising material social success expectations and aspirations in a marketplace where there is so little available of these symbols and have them accessible to poor people.

These are the issues which we need to address.

In the National Urban League, we first try to offer real hope and perspective because we believe that the issue of employment—of income and economic security—is crucial to turning people around in the Black community, particularly that portion of the community that does not participate actively in and thereby gain security from the market economy. And so, translated and broken down to basics, we believe we must begin not only to train people to work, especially in relevant types of jobs, but also to find places in which they can be anchored into the job world and then to use all means to support their staying in the job market. Setting a sound economic perspective and plan is crucial.

There are also other areas that require attention—primarily, the life situation of individuals and families. Apart from a lack of income, one factor that makes life for poor people so tough is not having regular and natural access to the normal supports—stable family, housing, helpful/nonpunitive service agencies, and other resources associated with daily living—that most of us have and could not function well without. This problem speaks directly to the brother who wants to get back home with his lady; the young man who has been released from jail and needs a place to live, a way to find a job, and an environment that

supports his adjustment back to civilian life; the sister who wants to work but needs child care and transportation to make it possible; and the couple who live together, the father earning very little and the mother wanting to supplement their income with light work but having to contend with the threatened loss of welfare eligibility due to "excessive income" or "a man in the house." The point is that the entire life condition of poor people must be addressed, not only on the local level, in the immediate community, but also on a national level within the public policy arena.

I suggest, however, that our community's social organization, its institutions, and its resource capacity will be crucial assets if we are to turn our community around and reverse a trend toward greater AOD problems among our people. At the beginning I spoke about the organization of the Black community. Unfortunately, sociological models of community research tend to fragment the context of Black Americans rather than emphasize commonalities and bonding strengths. We know clearly that a polarization is occurring between Blacks with incomes under $17,000 and Blacks with incomes above that amount, and there is very little middle ground between them. Increasingly, for Blacks to exist at all, they must have incomes that fall within the so-called middle-income range. I am not talking about the underclass here but about large segments of the Black population who work every single day, 7 days a week, 8 hours a day, 52 weeks a year, and yet their annual salary is still inadequate to live on. So what we have is an increased number of our population who work, live by the work ethic, and still remain poor.

I conclude that intractable poverty intertwined with racism fosters AOD use by youth, and even abuse of other individuals. Drugs in our community represent one more insidious substance that renders large portions of our community, beginning with the poorest residents, ineffective to address the real issues of a functional life. Drugs make it impossible for young people to concentrate on securing a job, building a career, or developing a family life. They render the users ineffective as instruments for change or as responsible wielders of power. Hence, while many factors fragment our community—and I have already spoken of community growth patterns, class factors in community development, and the impact of a new economy on an emerging larger class of Black poor people—I would nevertheless like to stress that we have the capacity, the strength, and much of the needed resources within our community to turn the condition around.

To reiterate, the first thing necessary is to have a correct perspective on the Black community and its importance. Let me say parenthetically that it makes no difference how much any one or two persons have or how successful they are deemed to be if, for the larger numbers, the system remains essentially closed and young people continue to encounter unnatural barriers to normal access and achievement. There is no greater need today than for Blacks to restore and

revitalize their community. We must look at the community systems of education, employment, family life, economic ownership, and so forth, and then we must look at ourselves to see how we can maximize our use, influence, and control of those systems. Then, when we begin to see ourselves, our strength, and the power we wield in the context of Black community institutions, we can begin to provide answers to the surge of abuse that exists in our community.

Our greatest asset, which is yet not fully mobilized nor energized, is our middle-class expertise, by which I mean the *quality* of expertise that can be found among this class of Blacks. This asset must be brought to bear on the condition of people in need in our community. Such people need the teaching of and training and counseling in management skills. They need those with skills to build new businesses and provide top-notch child care. They need many more indigenously managed service agencies and businesses in our community to provide needed and relevant services. Our current existing agencies must frame programs that relate directly to people and community development.

Thus, we have the capacity. All we need is the etiological perspective and the commitment to undertake this generation's great challenge: to restore and revitalize the Black community and the Black family.

Dr. Adair: My purpose here is twofold. First, I want to highlight how we perceive the issue of addiction so we will know what we are talking about. Second, I want to reflect on one subsystem within our society that perhaps has been the most turbulent of our time: education. Nothing has created so much turbulence in our society as the controversy over the rights of Blacks to get an education in America. Thus, I want to talk about that subsystem and specifically, about the classroom situation. I do not see a direct causative relationship between what happens in desegregated schoolroom settings and the incidence of drug addiction. However, desegregation is assuredly one of the forces that tends to serve as another pressure on young Black children.

I conducted research on addiction in the Black family, and in 1984 I published an article on my theory of addiction under the title, "The Dynamics of Addictive Manifestations: Toward a Theory of Addiction." What I said in that article—and what I still believe—is that addiction itself is a dynamic process. It is a motivational state, and excessive AOD consumption, smoking, and so forth are simply manifestations of what I call the "extremist motivational state," or EMS. Thus, to understand the cause of addiction, we must determine the individual's behavior pattern prior to the excessive consumption of AOD and so forth. In other words, there is a temporal factor. Those who discuss and study drugs often deal with the individuals after they are hooked. At that point, it is very difficult for researchers to identify the causes of addiction. But I contend that EMS exists prior to the onset of excessive indulgence and has its roots in socialization.

I will just give certain postulates that I have derived, which serve as the basis of my theory. Motivation is a "drive state" that ignites inner strivings toward some definitive goal. EMS is a kind of construct, a dynamic; that is, it cannot be seen except through its manifestation. It pushes an individual in one direction or another. Among my premises are the following:

1. EMS has its roots or origins in the socialization process.

2. This socialization takes the form of strict enforcement of rules, regulations, consistency, and scheduling of a child's life by parents and socializing agents.

3. There is strong advocacy for children to be exceptional. Families stress that it is not enough to be ordinary; one must be better than other people. Black families especially tell their children that they have to be better than whites to "make it." Socialization theorists have not been able to account for heroes. Socialization is supposed to teach a person to remain within the normative structure. Yet the hero supersedes the normative structure. So, on the one hand, there is a message to be normal; on the other hand, there is another message to be exceptional, which is highly rewarded through the socialization process. Therefore, there are forces operating within the system that allow these individuals to go beyond the ordinary.

4. EMS is a generalized dynamic motivational state, a way of responding to reality that takes an extremist form in terms of goals, strivings, and aspirations. In my research with Dr. Savage on the impact of heroin addiction on the Black family, we did not find low motivation and lack of goals as the typical pattern. Instead we found that these addicts have goals and aspirations but are often frustrated, and so the drive associated with these high motivational states often gets translated into illegitimate lifestyles.

5. Excessive indulgence, such as in narcotics, alcohol, tobacco, and food is a manifestation of EMS.

6. There is a temporal factor; that is, the addictive drive or motivational state develops prior to the excessive indulgence in these kinds of behaviors. And after the individual gets hooked on a drug or behavior, the behavior itself becomes an autonomous or self-perpetuating event; that is, the manifestation becomes reinforcing per se.

7. Addictive individuals tend to be narrowly focused. They do not have access to or are not attracted to the range of "usual" activities in which they can invest this extremist level of energy. So the energy becomes narrowly focused. Such individuals do what they do well, whether it is drugs, sports, crime, and so forth. The issue of availability and access to legitimate means of realizing goals

becomes a critical factor for the investment of this psychic energy associated with this EMS.

One chapter in my book, *Desegregation: The Illusion of Black Progress,* was titled, "Are Black Children Imprisoned in Desegregated Schools?" I asked a basic question at the beginning of this chapter: "Why would a Black mother proudly tell her neighbor that her eight-year-old daughter participated in a ballet in an integrated school play by playing her role in a trash can on the stage?" I think this example shows what is happening within the school system. In the early stages of the desegregation movement, there was massive firing of Black teachers. Therefore, the meager control that Blacks had, at least at the school level, all but vanished in the Nation's school systems. Along with this loss of Black control in the educational process went models of Black teachers and Black principals and reinforcers of Black identity and pride, such as the yearbook listing the "best dressed," "the best looking," "the most likely to succeed," "the most attractive," "the most ladylike," "the most shapely legs," "the smartest," "the tallest," and so on. These positive statements aggrandized Black youths; thus, such positive reinforcers were generated out of the natural environment.

And what happened when they desegregated the schools? They took the children from the predominantly Black schools, or the all-Black schools, and dispersed small groups of them all over the school systems, ensuring a minority status for Black children in a society that follows the majority rules. White (majority) schools make and enforce the rules within that school setting. As a result, Black children are moved from a Black-ruled school setting to a white-ruled one.

In addition, there is a situation in which white teachers do not understand the nonverbal cultural nuances and innuendoes that Black children typically use with adults and children. There is research that shows that white teachers grade Black children lower in the school systems, and that Black children are highly overrepresented in special education or remedial classes throughout the Nation's schools.

Thus, a typical pattern we find among Black children is "situational withdrawal." That is, the child ignores the school and merely sits out the time, which amounts to a kind of compliance or just getting by. Another pattern is what we call an "intransigence response," in which the child openly resists and rebels. The disciplinarian in the school system is usually the Black assistant principal. Thus, hostility develops between the Black assistant principal and the Black child. The Black child gets suspended, expelled, and so forth. In Des Moines, Iowa, for example, Black pupils represented only 10.1 percent of the school system, yet the percentage of Blacks under suspension was 68.8 percent.

This situation is typical across the country. Clearly, we are dealing with a very difficult situation.

A third adjustment pattern has the students essentially accepting white definitions. They acquiesce and incorporate these white definitions of themselves within that setting. Therefore, youths will often emerge from such settings not clear as to who they are. These individuals, who are hired by white-owned newspapers, have little or no commitment, in my judgment, to the Black community. That is the system's way of rewarding a Black person for accepting white definitions.

Therefore, my basic belief is that the desegregated setting—not the integrated setting—creates a situation in which extra and unusual pressures are placed on Black kids, which apparently is having a detrimental effect on Black children and on the Black community. I want to make this point very clear because I think we need to move away from desegregation and to integration where there is parity in the educational process.

Prevention Models for Black Youth at High Risk: Family and Religion

Participants: Dr. Hakim Rashid, *Moderator;* Ms. Rouvenia Brock, *Co-moderator;* Ms. Addie Key, Dr. Omowale Amuleru-Marshall, and Ms. Susan Meehan, *Panelists;* Dr. Sylvan Alleyne, *Recorder.*

Ms. Meehan: I am a DC public school parent. My son graduated last year with honors from Wilson High School, and he is now in college. That does not sound strange, I suppose, but to me it is really something of a miracle because 4 years ago, when my son was in the 11th grade, he ran away. We had to deal with St. Elizabeth's and with the police, all from the parents' side. With the help of God, my son succeeded and has been in recovery for 2½ years, and with the help of God, I can help other parents. I am currently writing a book, which will be called *No Dope,* about what to do if you are a parent of a "druggie" child. My testimony can help other parents avoid going through some of the things that I went through. Accordingly, I want to discuss what you as parents can do both individually and collectively to help your children and the children of your community avoid getting involved with alcohol and other drugs (AOD).

To begin, I offer nine points, which may help children stay drug free. These are backed up, for the most part, by substantial research that shows these points to be effective.

First, let your children under the age of 21 know that you will not tolerate their AOD use. Do not assume they know your attitude about this; they are not mindreaders. And why should you not tolerate it? For one thing, a child's brain is affected rather differently by AOD than is the brain of a mature adult. Brain tissue is destroyed in the immature brain when children get involved in AOD. It takes a child only 3 to 4 months to become addicted to drugs, whereas it may take an adult years. Also, if you tell your children, "no," it may have some effect on preventing their use of AOD.

And finally, if you do *not* tell them "no," they will think you are willing to disobey the law on the minimum drinking age. This is a message you really do not want to give your children. I would not allow them to have any sips of any alcoholic beverage—not even at Christmas, weddings, or other festivities. Attempts to teach drinking on your terms do not work. First, studies show that children do not need to learn how to drink; television handles that quite thoroughly. Second, if you abet your children's drinking, alcoholism could be the result of your permissiveness. Finally, other studies tell us that young people who do drink, drink in patterns that are quite different from those of adults. Seniors in the most recent national high school surveys reported that 31 percent have friends who drink five or more drinks once or twice a week, and 62 percent

saw no harm in that at all. These kids will almost certainly go on to become alcoholics.

The second point is that if you drink, do not involve your children in your drinking. Do not ask them to go to the icebox and bring out a beer for you. Do not ask them to make a drink. Studies have been done in Washington, DC, that show children will start to drink earlier if you involve them in your drinking. The earlier they drink, the more likely they are to become alcoholics.

Third, studies show a strong correlation between family alcoholism and children's susceptibility, and we now know that there are genetic factors involved. So, if your children have a close blood relative who is a drug abuser, it is your duty to lay out the risks to them and to tell them it is in their best interest not to drink before they are 21, or preferably never, and certainly not to use other drugs.

Fourth, a disproportionate number of children who are hyperactive or have learning disabilities go on to become drug abusers. If you have such a child, ask the school system, your pediatrician, or the DC chapter of the Association for Children with Learning Disabilities for assistance in obtaining diagnosis and treatment. And once again, you need to speak openly and frankly to your children, discussing their risks should they get involved in drug use.

Fifth, let your children know your moral values. Being a good example is necessary, but it is insufficient. You must be explicit with them about your beliefs, and you need to ask them to share these beliefs. (Even if they disagree, they will have done some valuable soul searching.) And if you are not a good example, you need to straighten up your act so that what you are saying is going to be believable. What you do and what you say must be congruent.

Sixth, you must communicate honestly and openly with your children. You must also offer them the dignity of being able to say frankly what they feel to you. They should be able to trust you with their feelings. Don't expect that you have to be a pal to your child. Being an open and caring parent is quite enough.

Seventh, offer positive alternatives. If your children have free time, check to see whether they have done their homework. Get them involved in scouting or in church groups. If they have too much time on their hands, find a way for them to fill it with worthwhile activities. Get them a job. Having too much time leads to hanging out on the corner, and you know where that is going to take your children.

Eighth, set limits for your children's behavior. Stick to these limits and have well-understood consequences for when they are disobeyed. If your children are continually excused when they have done wrong, they will not learn limits and they will not be able to become mature adults. If you remember reading about

the young people who preyed upon Catherine Fuller in the H Street corridor and killed her, you will remember that none of them had jobs or responsibilities. Their parents and grandparents gave them money and did not require that they work and contribute financially to the household. None of those young men grew up to become responsible adults. The world does not make excuses, and it does not help your children if you do.

The ninth and last point is to be alert for AOD involvement. If you notice it, do not deny it but act quickly because it is not going to go away; it is only going to get worse. Look over your children's companions carefully; be careful about them. If your children are beginning to act secretively or hostilely, or if they are cutting classes in school, find out what is behind it. Make yourself familiar with the signs and symptoms of drug use.

My second purpose here is to discuss what you as parents can do collectively through PARADE—Parents Rally Against the Drug Epidemic—an organization that is just being started in this city. The drug pushers are organized in this city. It is time that parents got organized, too, and that is what PARADE is setting out to do.

PARADE has two purposes: to supply parents with information and to help parents organize. First, as parents you need information about AOD and their short- and long-term damaging effects so you can speak persuasively to your children about these drugs and why not to use them. If all you know is "reefer madness," your children will not listen to you. You have to be thoroughly factual and up to date. Surveys in the District have shown that if you are well informed, your children will listen to you.

You need information about the signs of AOD use so you can recognize it when it is there. I was ignorant and paid the price of my son's addiction. Let me give you an example of my naivete. I went into my son's room one day, and I saw a big, empty bottle of vodka lying next to his bed, so I asked him, "Chris, what is this?" And he said to me, "Mom, you know I have an aquarium." And I replied, "Yes." And he said, "Well, my fish just died and I wanted to preserve it. So I took the water out of the aquarium, and I filled the aquarium up with the vodka in that bottle." I believed every word he told me. I was that dumb. I did not know the signs and symptoms of substance abuse. Do not be in that position. You need to learn the signs and symptoms, and we hope that, through PARADE, people will be a lot smarter about them than I was.

In addition you need information about available self-help and treatment programs. There are many such programs here in the District. If you have a child who is using AOD, you need accurate information about such facilities and you need it fast. One place to turn will be PARADE.

You need information on ways to communicate with your child, and you need information from the executive and legislative branch on alcohol- and other drug-related issues. We intend to provide it to you.

Finally, parents in the District feel isolated in dealing with the problems of drug use in their family and in their neighborhood. We want to let them know what other people in other groups across the city are doing, what kind of successes they've had, what works, and what does not work. There are good programs going on, and we need to share this information so we can come together and realize that we are not so alone as we might have thought.

PARADE's second purpose is to help parents organize. We are going to start by organizing on both a neighborhood- and a citywide basis to fight AOD use. Parents collectively have a lot more strength than they do individually. We need to join together to tell our kids "no" when they want to engage in unwise activities. Many parents have kids who have said, "Well, everybody else's parents let them do it." We have been taken in by a scam here. If we join together collectively, we can stop that.

Finally, community residents and parents want action against open drug pushing. The lack of a united citywide organization to sponsor well-planned antidrug activities has been a deterrent to community action. I am not saying that we are going to be able to go down and cleanse the city, but if we do not get started together, we are never going to be able to do anything.

We intend to do all these things and more through PARADE. We are going to start organizing one neighborhood in each ward in the city. It is not necessarily going to be the worst neighborhood. It is not necessarily going to be the best neighborhood. It is going to be a neighborhood in which parents indicate some interest in getting organized. And with the help of the school system, we are going to have some locations that are right within the community. Once we get started in an individual neighborhood and get parents together, we are going to carry out some activities on a local level. Then, after we have built up a critical mass and shown that we can work well, we will move into other neighborhoods and start on a wardwide level. Only when we can pull off activities well on a ward level will we move into a citywide level. PARADE is not going to be a down-from-the-top organization. It is going to be a grassroots—if you will pardon the expression—up-from-the-bottom organization. We will publish a newsletter. We will keep everybody informed. We will work together.

Ms. Key: I am going to describe a model for inner-city drug use prevention. I say "inner-city prevention" simply because that is where we started. However, if it is a model and if it is successful, it can be replicated wherever needed, based on adaptation, and that is what we have done in a very successful project in East Baltimore.

I began with AOD use prevention in the latter part of the 1970s in East Baltimore because, according to the police department, our efforts for juvenile delinquency prevention would not be successful until we started dealing with AOD use. They were telling us that 85 percent of crime at that time was drug related. Of course, at that time, we who came along in the 1940s and 1950s were not aware of the extent of drug use or abuse. We lived with alcohol and other drugs every day, but we just were not aware of what was going on. We did not know at what we were really looking.

At that time, I was working for the Baltimore City Department of Social Services as a community resources coordinator. One of my major programs was finding jobs for youth to help them gain employment readiness skills, good work habits, and the kinds of things young people need to learn about working and not just collecting a check.

The recruiting officer for the Baltimore city police department's Cadet Program came to my office one day. The cadet programs are fantastic: they offer very good opportunities, not only on the job but also for the future. One benefit of this program was that the young person would become eligible for a free college education with no strings attached and without having to commit any time at all to the police department. But the recruiting officer was sitting in my office with a big problem: out of 300 applicants, only 40 were drug free. I was just shocked. Since no one is stupid enough to use drugs and go for a police physical, I realized that there was something that neither I nor the kids knew about drugs. That realization encouraged me to find out about drugs and the drug problem, and I learned a lot.

I learned to recognize what was looking me in my face every day, and I began to communicate to the kids what I had learned. However, I knew that I was not going to do anything about this problem without some help. I also knew that there were many people just like me, working in agencies, living in communities, and wanting to do something but just not having a mechanism for doing it. But the real thing that made me go and pull together a plan and an organization was something I identified as being helpful in combatting the problem. It was to help kids gain more self-esteem.

I decided that a newsletter that would recognize their achievements within their elementary schools would be effective in boosting self-esteem, especially considering the attendance problems in my district—the worst attendance record in the whole city. To help those schools improve their attendance records, we decided to publish a perfect attendance list with other achievements to which the kids would really respond. I created such a newsletter within my Social Services district office, we published it the first month, and it was acclaimed by everyone. We were distributing to all 13 elementary schools within my district, about 5,000 newsletters every month overall, according to our plan. When we

published it the second month, however—again, to much acclaim—my district manager was told that despite its being a very good newsletter, it had not been budgeted in that year; thus, as much as they would have liked to continue it, the department just could not afford the paper I was using.

Of course, I immediately began to think of how we could continue to do this newsletter. I simply called up friends. It frequently happens that your friends are those persons with whom you have been working in agencies all around the city. You call them together and sit them down and say, "Now, what can we do?"

To digress for a bit, another good thing about my generation is that we all went to school, and we all went to church. That is all we could do. Thus, because of my work with youth employment readiness, I knew all those places where people work together to help each other, and the one place in particular that I thought about was the church. Now, there are those who bypass the church or whatever the religious organization is that they know, but it is there somewhere in that community. And it is a powerful structure—or it can be, with change. When I do an interview and application form with most people regarding personal data, one of the things I ask for is church affiliation. I do not care what kind of god a person serves or what kind of beliefs that person has, though I have my preference. All I want to know is what kind of relationships and what kind of socialization that person is getting as he or she goes through life. I was once trying to prepare 40 young people to go to work for Social Services and Social Security during the summer, and out of those 40 people, only 8 went to church. That was the same summer the policeman came to me with his 300 applicants that included only 40 drug-free kids.

This was my perspective when I sat down with my friends. We talked about the problem and decided to try to do something about it. We looked at our neighborhood, and we realized that one of the problems was that it had become a "strangerhood." We just did not know one another anymore. Johnny could run around the corner and snatch Ms. Brown's pocketbook because nobody knew Johnny. When I was young, I could not go across town, let alone around the corner, because before I could get back my mother would have heard several times that I had gone. And it better not have been at a time when the person felt I did not belong there. All I am saying here is that much of the crime that was happening in my community was because little kids—and sometimes they were *very* little kids such as 6, 7, and 8 year olds—could run around the corner, snatch a purse, break a window, grab a VCR or whatever, and run two blocks down the street and start walking, because nobody knew them. That was one problem.

The other problem was who was going to do the job. All my friends had moved outside the area. Nobody who was "anybody" was living in the inner city anymore unless they really had commitments there. It just was not the

fashionable thing to do. Regularly somebody would ask me, "You still live with those people?" I still live with those people. I still ride buses, and I still just like doing those things I used to do because it keeps me in touch. And I suggest that anybody who wants to know what kids today are thinking should catch the bus between 7 and 9 in the morning, sit quietly, and listen to them talk as they are on their way to school.

But to go on with my story, in that group we had members of agencies from all over the city, all of whom knew what resources their agencies had. The people in need may not have ever heard of these resources but the people who have the resources know what they have. And I suddenly realized, as I sat with these people and we were all sharing, that in that room I was the only person who knew what everybody else had because I had made it my business to know what resources were coming into the city. And then I began to tell the others in the community and in that room the method to my madness.

I read the front page of the paper every day. It tells me what Congress is passing and what regulations are coming in. Then I turn to the front page of the community section to see what is coming into my city. Every time there is a new administration, the alphabet soup changes. It does not go away. It just changes. So it is up to us, if we plan to make an impact, to keep up with changes.

In that room we had people from Social Services, the Board of Education, the Department of Recreation, Mayor stations, because in that community that I am describing, we had five of everything. We had five mayor stations, which brought City Hall right into one's district. We had five Urban Service Centers, five Social Services Departments, and five Health Departments. We also had a church and a bar on every corner, with maybe two or three in between. We had a lot of senior housing and a lot of family public housing. We had a lot of good-hearted people. We had a lot of everything. But people were not working together on this problem.

So we decided to do something about AOD use but not by going to the top. At that point, everybody who lived in that area certainly had a reason to be concerned. But because the people who lived there were not necessarily the people who could really make the biggest impact immediately, we needed to involve others who were just as concerned about that community. And if they did not know they had a concern about it, we needed to help them to know. So we said that people who are concerned about that community are those who lived there, who worked there, and who worshiped there.

Now, at 11 a.m. on Sunday morning outside a big church in an inner-city neighborhood one will find everybody who cares about that community. They probably joined that church when they were infants. Their mamas were there; their grandmamas were there; their papas were the deacons. What it all means is that they have a reason to care about what goes on in that neighborhood, if

for no other reason than to protect their own personal safety, their pocketbooks, hubcaps, car windows, and tires. We know that all sorts of things can happen between 11 a.m. and 1 p.m. on a Sunday. Walking to and from work in an inner-city neighborhood can become quite dangerous, as some Social Services workers know from having their purses snatched as they passed an alley. Concerns about safety get people to come together.

To get people to work on a project voluntarily for a long time, however, takes real commitment. For an agency to give its resources, the leaders and members of that group or the community should be people who really are committed to that program, that project, those kids, or that family. So we went from the bottom up. We found out who wanted to do the job. Then we wrote to the director of the agency, saying, in effect, "We are about to form the Neighborhood Action Coalition for Substance Abuse Prevention in the Second Councilmanic District of Baltimore City, and we would like your agency to participate. Because we have been working with Ms. So-and-so, who lives in the neighborhood, would you be so kind as to assign her to our committee?" That worked. We got the human resources that we needed. But we also needed time.

After we started this project, it was over a year before we had the people who were going to be the major players in it. The Neighborhood Action Coalition had churches at the core. Churches have the resources. They have the mandate from whatever their book of record is. They also have the people. And if there is anybody in a community who is going to be drug free, or at least profess to be drug free, it will be the members and leaders of the churches. So that is one reason—or several of the reasons—why we really chose churches as the core of our organization, and most of what we did with the kids came out of the work of the churches.

And what did we do? First, much of what was happening with kids and drugs was based on this attitude: "We just wanted to have a good time. We were trying to have some fun. There was nothing else to do." Although other reasons tend to crop up about their having problems and so forth, they said that was not true. They really wanted to have a good time. So we knew we had to find some other ways of helping them to have a good time. Those old-fashioned ways we used to use—going to ballgames, having clubs—all those little things somehow or other disappeared from our neighborhoods during the 1960s and 1970s. We just had to get people committed to trying to put those things back.

However, we did not have any money. Again, we could not even afford the paper out of my agency. So we wrote a proposal for the State Department of Health and Mental Hygiene, Alcoholism Control Administration. They gave us $5,000, which paid for the paper for our newsletter. Then, with the help of Project 13, which is a group of churches who come together to provide food and other emergency services, we enlarged our effort in alcohol and other drug use

prevention. Project 13 became one of our major leaders. And I say "major leaders" because there were about 20 churches involved. And in addition to Project 13, we had what was called the Apostolic Outreach Center, an old school building that was given to the church group to provide whatever services it wanted within the community. The center gave us space in its building to do what we wanted. And that school building was a delight. It had everything: gymnasium, library, large space, and so forth. In addition, we had a wealth of community resources. The Department of Education had lots of films and resources, audiovisual equipment and books; the library had all those nice books; and the Recreation Department had money for trips, it ran a day camp every summer, and it gave boating lessons. Manpower Services, in addition to helping with jobs, also provided trips for the kids in the community, and the Jaycees, who have a "Take Me Out to the Ballgame" program every year, offered to give a community group up to 150 free tickets to go to a ballgame. However, the community folk just did not seem to be able to get it. Somehow there was nobody to organize things and get what was available for the kids.

So all I am saying is that with $5,000, the commitment of professional people who live, work, and worship in the area, recipients of Aid to Families with Dependent Children (AFDC) who are the parents who may not have had a junior high school education, and with the kids themselves, we made an impact. There was no magic to this process. All we had was concern for that community. We formed what we called a neighborhood network. People on every block in that district were part of this group. Their job was to find out problems and bring them to our attention. They also distributed the newsletter and recruited kids for the activities we had.

As we all know, together we can make a difference. The statistics showed that over a 5-year period we accomplished a lot. The first year we used to get the project together. The second year the people had to find out about us and believe that we meant what we said. So for about 3 years we have actually worked, and we have cut the delinquency rate down from over 113 children to 53 children.

There are some folks in the medical community, in the academic community, and in other places who really do not think prevention works. But we who are out there in the streets beating the bushes in a grassroots effort, we know it does.

Dr. Amuleru-Marshall: The Cork Institute on Black Alcohol and Other Drug Abuse was established at the Morehouse School of Medicine with an endowment from the Joan B. Kroc Foundation just over 4 years ago. The charge of our institute is threefold. First, we seek to introduce into the standard medical educational curriculum, at the undergraduate, residency, and continuing education levels, information, illustrations, and applications about drug abuse among African-Americans. We do not have an amorphous ethnic minority kind of

agenda. We were asked specifically to focus attention at drug abuse among Black people, and to do that as a part of our medical educational effort. In this particular way, we are also trying to affect medical and other health professional education nationally. Second, we also seek to develop independently, or in collaboration with other national organizations, demonstration projects that are culturally innovative and relevant. And finally, we want to have at the Morehouse School of Medicine in Atlanta the national repository of audiovisual and print material concerned with education about and the prevention of drug among African-Americans.

Now with respect to the theme of this presentation, I intend to provide a quite opinionated survey of the prevention agenda, highlighting the Black family and the Black church. I hope that it is informative; but I hope, even more, that it is stimulating in that it serves to capture your interest and, most of all, inspire your personal commitment.

I want to begin by rethinking certain definitions that are gaining currency among establishment professionals in the drug abuse field. The notion of high-risk youth is a provocative one, in my view. We need to be sensitive to victim-blaming mystifications. I want to propose that all Black people, but particularly Black men, represent a high-risk group. We are at comparatively high risk for sickness and death. This vulnerability is represented by a consistent pattern that emerges at infancy and develops in a rather sinister and predictable way throughout our tragically abbreviated lives. We are at comparatively high risk for mortality, morbidity, and incarceration. In his important book, *Frantz Fanon and the Psychology of Oppression* (1985), Dr. Hussein Abdilahi Bulhan makes the point that sociostructural violence is the most lethal form of violence because it is the least discernible. It causes premature deaths in the largest number of persons and presents itself as the natural order of things. He suggested the most visible indicators of sociostructural violence in any society are differential rates of mortality or death, morbidity or sickness, and incarceration among different groups in the same society.

While I applaud the special attention being given to AOD abuse at this conference, we cannot afford the preferred-problem myopia of establishment addictionologists. AOD abuse, in the experience of our youth, is just one of the horsemen of the apocalypse. What we must aim at preventing is not a mere symptom of a crisis, a mere consequence of the apocalypse, but, ultimately, the apocalypse itself. A public health or preventive approach forces us to clarify etiological relations and conditions, so that we may design our strategies to change those which we selectively perceive.

The perspective that I espouse is nurtured by the work of the late Afro-Caribbean psychiatrist, Dr. Frantz Fanon. In his view (1968), "the events giving rise to the disorder are chiefly the bloodthirsty and pitiless atmosphere, the

generalization of inhuman practices, and the firm impression that people have of being caught up in a veritable apocalypse." Dr. Wade Nobles, in his book *Africanity and the Black Family* (1985), asserts that "without question the fundamental proposition historically affecting Black people [in the] new world has been cultural domination." Indeed, the late, Senagalese multidisciplinary scholar, who many regard as the pharaoh of Egyptology, Cheik Anta Diop, elucidates this fact in most relevant terms (1986): "Thus imperialism, as the hunter of pre-history, killed the being first spiritually before seeking to destroy it physically." There was ample evidence, even before the debacle of AIDS, that we are now in the last stage—that of physical destruction. Note that with the exception of suicide and pulmonary disease, death rates among Blacks for each of the leading causes of mortality in the United States are excessive (NCHS, 1988). Black men are, with sinister consistency, most threatened in every instance. Now, anybody who has had Statistics 101, who understands the most elementary notions of probability, must know that one cannot, by chance, come up with a consistent and, as I say, sinister pattern of violation disfavoring Black men unless there is something rather methodical and systematic operating in our midst.

I suggest that prevention strategies, if they are to enjoy durable success among us, must be designed to achieve the following purposes. They must include efforts to restore our people's memory. They must aim at reclaiming our people's identity. They must seek to develop our people's culture and to reestablish our control over the socialization of our youth. They must be designed to achieve our autonomous accumulation of resources. By the same token, prevention models must be designed to restore a sense and experience of communalism in our communities. That is, they must augur for and establish the destruction of intra-Black segregation. And finally, they must seek to restore spirituality as the essence of life and, in that process, disabuse our community of the notions that we exist only to acquire, that we are what we have, and that the purpose of living is to possess "Babylonian trinkets."

I wanted to establish this context before venturing to discuss specific models. This perspective fosters the consciousness that we cannot go to the establishment literature or practice for models that will be appropriate to our experience. The assumptions and framework that spawn these models are fundamentally different; indeed, they are dialectically opposed to those that appropriately derive from our realities. As I said earlier, a given approach to drug abuse prevention presumably depends on an analysis of the factors that cause and support it. The major primary preventive models can be said in summary to be based on the etiological premise that drug use is caused by a lack of knowledge about the deleterious effect of gateway drugs and the consequences of their use and sale. Most conventional models address certain types of drugs that are commonly abused, the ways in which they are used, as well as the ways in which they affect the body and mind. Some include information about the

relevant laws governing their use. Some of the better regarded approaches seek to enhance social competency and individualistic self-esteem.

Although Black youth were caught up in what I perceived as the just say no hysteria that swept this country, lasting preventive impacts will depend on our teaching our youth not to say no, but to say yes—yes to our name and to our ethnocultural nationality; yes to a sense of history, yes to self-determination as a human right; yes to the harsh reality that we are oppressed; yes to our traditional culture, spirituality, and the values that result from these. We must disabuse ourselves first, and then our youth, of the illusion that we are living in a kind of post-civil rights nirvana and that there are no longer any realities of racism (both micro and macro), and other forms of cultural aggression, poverty and classism, and so forth. One way to foster this acceptance is by telling our story again and again. The restoration of our memory through the regurgitation of our story is crucial to the enhancement of self-esteem. It should be noted that the nurturing of individual self-esteem requires the prior cultivation of collective self-esteem. This notion is captured by John Mbiti (1970) in the slogan, "I am because we are, and because we are therefore I am."

One of the most well-reviewed developments in the primary prevention of drug use is the parents' movement. With thousands of parent groups across this country, this movement is enjoying some measure of success in mainstream preventive efforts. Certainly, African-Americans have participated in this movement and have even provided leadership on some levels. Yet it must be pointed out that the parents' movement has some particular limitations with youth sequestered in high-risk environments. High-risk or multiproblem youth come from multiproblem families. AOD abuse is commonly found to be among other perplexing social problems that beset these families. Particular strategies that might be useful in these circumstances include adopt-a-family innovations. Volunteer families might be encouraged to establish long-term relationships with matched drug-abusing or multiproblem families. I also propose retribalization as a means of reconstituting families across bloodlines, or perhaps more accurately, without regard for bloodlines, as another useful innovation. It has been pointed out repeatedly that in the experience of many Black families, it is not uncommon for there to be strong familial bonds without respect for blood relations (Brisbane and Womble 1985).

Both of these special strategies designed for multiproblem or high-risk Black families are appropriate programs that church congregations can sponsor. Not only do churches have adequate facilities for these and related activities, they often also have a pool of volunteers, the administrative acumen, and other requisite resources. Perhaps the most important qualification of the Black church is its fiscal and functional autonomy. As W. E. B. Dubois noted (Nobles et al. 1987), "It is our only social institution which was started in Africa, and which supported our survival inside the United States." The Black church is the

logical institution, therefore, to lead in the restoration of our memory, our identity, our culture, our dignity, and, indeed, our spirituality.

Let me mention at this juncture some other special attributes of the Black church. In addition to offering large physical plants and auditoriums, pools of volunteers, and programmatic resources, the church also offers significant numbers of easily accessible client populations. The church often provides an alternative point of access to certain hard-to-reach elements in our community. Moreover, as a social institution the Black church has long enjoyed the acceptance, endorsement, and confidence of our community (Davis 1986). It would certainly be consistent with the Black church's historical role for it to be a vanguard institution and assume a catalytic, values-clarification function with respect to drug use. Unlike establishment models, however, this values clarification is on a community level, not on an individual level that many churches already do.

We are reminded by Peter Bell (1986) that the following questions must be answered as a community of families and individuals. The first most important question is what, if any, mind-altering drugs can we afford to permit the use of in our experience? Other questions then follow: Who among us will be permitted to use them? When will this use be considered appropriate and adaptive? Where will this use be permitted? Why, or under what circumstances, should these drugs be used? And, perhaps most importantly, how should one behave in the presence of this use or under the influence of these drugs? These judgments must be made with only secondary regard for the legal and normative practices and mainstream, white America. It is important to foment as wide a debate as necessary to penetrate our denial of the abusive potential, cost, and lethality of nicotine and ethanol.

It is difficult for the highly regulated use of any substance to develop into abuse. The clearer the line is drawn, the easier it is for everybody to appreciate when it is crossed. There are really only four relationships that can evolve between a consumer and a *mind*-altering drug. The individual can use it experimentally, socially, problematically, or abusively. If we, as a community, have a clear determination as to what is appropriate and what is not, we can easily determine when use becomes abuse long before people develop dependencies (Bell 1986).

There are a number of examples that suggest that mind-altering drugs have long been used in organized human experience. These have traditionally been closely knit, highly regulated societies in which the use of mind-altering substances existed with low levels of abuse. In these contexts, however, there was a widely known, clear determination of which drugs were used and when they could be used appropriately. I am not implying that we have to be opposed to all drug use in order to move against drug slavery. I am not necessarily asking you

to become abstainers. I am, however, suggesting that we, as a community, actively catalyze a debate to determine ultimately what, in fact, is appropriate for us to use, given the realities of our situation. You see, smoking and drinking parents are often in a most perplexing contradiction as they attempt to hold the line against their children's marijuana or cocaine use. We need to define the appropriate conditions of any use in very clear terms. Our churches must nurture this debate.

The Black church also has a critical advocacy role in the social policy arena of primary prevention. Its responsibility is to lead and to challenge other Black organizations to conduct their affairs in a manner that is consistent with the interests of the community regarding *mind*-altering drug use. Many of our organizations find their roles as advocates for our community's health compromised by their indiscriminate fund-raising practices. Black sororities, fraternities, social and professional organizations, service agencies, and other media must all support and reinforce healthy behavior. I think it is time that we as a community begin to state, through our organizational vehicles, that certain kinds of practices will not be endorsed and I am suggesting that the Black church can serve as a catalyst in this regard. The aggressive criticism of Black media, *Essence, Ebony, Jet,* and others, who exchange our health for advertising dollars, is an important aspect of the church's mandate. The mobilization of its membership networks and of the larger Black community to impact such issues as advertisement, availability, price, drinking age, and impaired driving laws is also an entirely appropriate activity for the Black church.

Secondary preventive interventions are principally concerned with screening for early onset or special vulnerability in known high-risk groups. I choose to include the following observations because the church has some special responsibilities and opportunities in this regard. Because a significant proportion of the Black community participates in the church, the clergy ought to be trained in the need for, and methods of, making an early diagnosis (Brisbane 1986). This training should emphasize intervention without waiting to be asked, knowledge of the denial defense, and pastoral followup after referral to treatment. Unfortunately, the level of participation by the Black clergy is less than acceptable. Our clergy are still ambivalently struggling with the disease concept. They are still not sure that they can reconcile it theologically. Many black ministers are still dealing with turf issues and loss-of-control phobias, which inhibit their effective involvement.

Some of the more effective overtures to the Black clergy have been guided by the following practices (Davis 1986): First, the influential clergy in local communities are identified and used as organizers. Second, the activity is given to the clergy so that it is owned by them, with health professionals merely offering themselves as consultants. Finally, and perhaps most important, doctrinal flexibility is built in, so that one recognizes that there may have to be a belief

orientation that is not necessarily consistent with the best thinking in the addictions field. However, it is important to respect the particular theological bias of that minister or congregation, as long as it does not compromise the effectiveness of the program. Work with, rather than against, the flow.

Churches offer special challenges but must be approached because, as indicated earlier, many people who have early signs of abuse can often be identified in congregations. I am suggesting that, except for strictly evangelical and charismatic (pentecostal) congregations, there are people who are active in the church who are already using and abusing drugs or drinking problematically. It is also not unusual to find active church members, even ministers, who are actually addicted. These congregations represent a screening opportunity.

A few additional thoughts: Given the relatively resource-rich and autonomous position of the Black church in communities that are service deprived, churches must be encouraged to sponsor more intervention and treatment programs collaboratively. They can, at least, expand the availability of culturally comfortable, self-help groups such as Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, and Alateen. As we think of Alateen, one of the most demanding areas of early intervention is concerned with children of alcoholics and of other drug-abusing parents. There is no controversy anywhere in this field concerning the comparatively higher risk to drug abuse that both familial *addiction* and growing up in an *addicted* household represent. There are screening instruments already available to identify these children. Yet the level of identification and screening of Black children of alcoholics or of drug-abusing parents is less than satisfactory. Some indications are that the risk is complicated, at least among women, if the drug-abusing parent is the mother. With more than 50 percent of Black children living in single female-headed households, this need for screening, identification, and service is clearly underlined.

Indeed, in the addictions field of adult children of alcoholics, the exploding reification of issues and specializations is to be criticized. Yet despite this fetishistic tendency, we must acknowledge that Black adult children of alcoholics and other drug-dependent parents do present some special needs. Conservative estimates are that one-third of children of alcoholics become drug abusers. Another third marry drug dependent people. A larger proportion do both, while almost half are treated for physical and emotional problems related to the dynamics of codependency. Very few, less than a fifth, get treatment for their primary problem (Brisbane 1985). This arena is clearly one in which the Black church offers some special opportunities. Black adult children of alcoholics and of other drug abusers are accessible there. They are in our churches, often with unresolved issues.

Let me conclude by inviting you to join me in the reaffirmation of a commitment to which my effort is dedicated: "I am committed to the spirituality, humanity, and genius of African people, and in our pursuit of these values. I am committed to the family, and to the community, and to the community as a family, and I will work to make this concept live. I am committed to the community as more than the individual. I am committed to constant struggle for freedom to end oppression, and build a better world. Therefore I pledge to struggle without fail until we have built a better condition than our people have ever known." (Modified creed of the Association for the Study of Classical African Civilizations.)

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Prevention Models for Black Youth at High Risk: Education and Media

Participants: Mr. William Johnson, *Moderator;* Ms. Selina Smith, *Co-moderator;* Mr. Henry Osborne, Ms. Joyce Tobias, Ms. Hannah Chambers, Ms. Reba Bullock, and Dr. Denyce Ford, *Panelists;* Dr. Eleanora Isles, *Recorder.*

Mr. Osborne: Our project, Beautiful Babies Right From the Start, is a model of a project that has all the right elements needed for an effective drug prevention campaign. It is broad, it is visible, it is focused, and it has an action step.

First, our campaign is broad. We appeal to the same concerns in everyone. For instance, I do not have any children, and I do not want to have any children. Why should I then be concerned about babies? My concern arises from two factors. One factor is the belief that children are our future; the second is the economic impact. Any incidence of infant mortality or any baby with a low-birth weight costs us something in health insurance and the like. By the same token, why should a middle-class couple living in Fairfax with no children be concerned about what is essentially an inner-city Black problem in Washington? Our project must be broadly focused to reach them. A drug project or model should have that same element.

It should reach the total community—not just people who abuse drugs but also those who are concerned about drugs. It should make someone who does not have any interest in drugs sit up and take notice. For instance, I am interested in drug prevention because of the economic impact of drugs on our community and because of the crime and the criminal impact of drugs on our children. We ought to be concerned about the children in our community. That should be one of the primary elements of a model for the media.

Second, the campaign should be highly visible. Our campaign uses all the media, not just television, radio, and the print media, because the most effective campaigns reach everyone. Our campaign also has frequency. It is not just a public service announcement that airs at 6 o'clock in the morning, not to be seen again. It is aired throughout the broadcast day.

Similarly, when people get up in the morning and their radios go on, there should be a message on the radio saying, "Drug use is a problem. Do something about it." When they get up and turn on the television to the "Today Show," Bryant Gumbel should be interviewing somebody about drug use. There should be an article in their morning newspaper about drug use as well as in the magazine they read later in the day. When they get in the car and are driving to work, there should be a program on the air about drug use. Similarly, the bus

in front of them should have a bus-back advertisement that urges people to prevent drug use.

Furthermore, the campaign should encourage television stations and even Hollywood to incorporate the drug message into their programming in a positive way. The message has to be reinforced to be effective. In the absence of reinforcement, you have just isolated drug messages.

Not only should the campaign reach the total community, but also it should be focused on the specific community that is using and abusing drugs—namely, the young adults, the children, and the drug users.

And finally, the campaign should have an action step. It should tell people to do something to cause somebody to write, to join in, to participate, or to get help.

Those are the elements a television station or other media would look for in designing a model for an intervention project for drug use. That is what we have done in our Beautiful Babies campaign.

To give an example of a bad campaign, our network told us to produce public service announcements that simply say "Just Say No" as a part of an NBC Network initiative.

How effective is it, though, for Nancy Reagan to appear and say no? How many kids or adults are going to listen to Nancy Reagan saying no to drugs? But we were told to do this and we did it.

We produced 13 public service announcements, which is a lot, and we aired them throughout the broadcast day. One spot featured Arch Campbell, a local movie critic, delivering a drug message, and we got some positive responses. People said, "Arch, just say no." They responded to him, he felt good about doing it, and we felt good about doing it. But have we stopped some people from using drugs? I do not think so. I would be very surprised if someone said, "I saw Arch Campbell, and I stopped using drugs." Similarly, we also had a nice cute spot of the "Cosby Show" children with a drug message. It looked good. It made people feel good. But, again, was it effective? I do not think so. I do not think we cured the problem of drug use in Washington, DC, or in the metropolitan area. I do not even think we caused one person to stop using drugs. And yet, we could say to ourselves as a television station that we did our part, and when they went to the White House Conference on Drug Prevention, our network officials were able to say that they had mandated their television stations to do something and that something was done. But have they really prevented drug use? The answer is obvious. Neither of these campaigns had an action step. The action step was just to say no.

By contrast, Aetna Insurance aired certain spots during the World Series in a very effective campaign that, I think, had a lot of potential. In these spots a

father goes to pick up his son after an event and gives him a disappointed look because the son appears to be drunk or drinking or maybe using drugs. The father says, "I thought we had an agreement?" And the son responds, "Well, Dad." And the father says, "Well, I am really concerned. It is going to hurt me if you get hurt, if you die, or if you become a drug user," or something like that. Apparently, the son had signed a contract with the father. That was an action step. That was something that forced the father to talk to his child.

This assumes that teens have a mother and father in the household who are able to have an enlightened discussion with them about drugs. Most households that we are talking about reaching do not necessarily have that traditional model—a mother and father who are capable of communicating with their children.

So what is the answer? I have not seen the model yet, the perfect drug use campaign. But I know what the elements are, and I think if a lot of smart people get together they could probably devise an effective campaign.

We had the same sort of mandate in Washington, DC, for our Beautiful Babies Right From the Start Campaign. Infant mortality was a serious problem in Washington, and we wondered what we could do to solve the problem. Our campaign reaches the same audience, basically—the inner-city Black community where there are problems with drugs, teenage pregnancy, and single heads of households. How, then, do we respond to the upper middle-class couple in Fairfax, who thinks infant mortality is not their problem? How do we make them concerned about it? They are the same people you can reach about drugs by saying, "It is a problem for you and you need to get involved with this, also."

Our campaign has frequency, some bus-backs, a radio campaign, and other actual events. It is an extended campaign. It has run for 18 months. All campaigns should run for a long time.

Our campaign also has an important action step: our coupon book that contains a lot of information. An expectant mother has to take steps to get the coupon book and to use it. By calling the March of Dimes, we obtained and distributed more than 36,000 of these coupon books throughout the metropolitan area during a 9-month period. It took us about a year and a half to develop that project: to do the research, develop the coupon book, and make sure we had all the necessary elements.

I am sure that with bright people who are dedicated to the cause of drug prevention, something can be developed that has all the same elements in it so that it can make an impact on drug use.

Ms. Bullock: I am the drug use prevention specialist for the Maryland State Department of Education. Prior to my entry at the State level, I was the health

education specialist for Baltimore city public schools for 7 years. I was a classroom teacher, and I have taught all grades. And I have supervised at the elementary, the secondary, and now the State level.

"Prevention Models for High-Risk Youth: Education and Media," certainly we should not separate the two because both can work effectively together to bring change in a positive way. Rick Little from the National Quest Program said that "the hope of every Nation of the world is in its young people." We have the opportunity to touch the lives of young people every day and everywhere through our understanding, our guidance, and our teaching. We have a responsibility and we are touched in some way by that, indirectly if not directly. We can affect history; and I believe that strongly.

National and State polls reported recently that drug use is the number one problem in our country. It does not matter where we ask, whom we ask, or what segment of the population we ask. It does not matter whether we have children in school or whether we feel we are not directly involved in alcohol and other drug (AOD) use and abuse problems. Drug abuse seems to be an overriding issue.

The world we live in today is a drug-dependent society. If we have a headache, we take an aspirin. If we have a cough, we take some cough medicine. Pain does not feel good. Everyone wants to feel good. So what do we do? We take a drug and alter our body's system to affect feelings. And that is what drugs do.

I have had kids ask why there is such an emphasis on drugs when so many people are taking medication and some people are drinking and smoking and yet are not treated as *addicts*. We must begin to look at the uniqueness of an individual, at that person's chemical makeup, and at his or her body chemistry.

Drug use is dangerous to all segments of the American population, but it poses a special risk for youth and young adults. The younger a person is when he or she first tries or experiments with drugs, the more likely it is that that person will go on and try other drugs and become involved in more than just one drug whether it be marijuana or alcohol. To become drug dependent and continue the use into adulthood in many instances offers a great risk and sets up many hindrances that interfere with that individual's becoming a productive person. Often there is the retardation of social and intellectual growth. Such use may deny young people the opportunities they are capable of seizing and need to function in the demanding society of today.

But when we tell kids that all drugs are bad, we are overstating the issue. All drugs are not bad. In many instances they help us. They become a problem, however, when they are misused or abused. At the same time, we are not saying to our adolescents and youth to take drugs with moderation. We want them

never to begin. We want to give straight messages that will let them see the danger of use and abuse of AOD.

Now, in terms of prevention models, I have been in Washington, DC, speaking to many different groups because I am an advocate for youth, not only in my daily occupation but also in my personal life. I work with over 35 youngsters weekly in my church and my community to provide positive experiences so that they can look at alternative behavior to AOD use.

But until we begin to build self-esteem in our children, we are not going to see any change. Thus, we have to take the responsibility to effect that change by not saying that it is Social Services' business, the drug treatment centers' business, or the schools' business. It is everybody's business because alcohol and other drug use affects all of us and we all have to be involved. And nationally, that has begun to be the case.

When we look at prevention models, let us start with the Just Say No program. Last year I was the person who instituted Just Say No clubs at the sixth-grade level in every middle school in Baltimore. I was able to take those kids to the White House to observe President Reagan sign the Anti-Drug Abuse Act in October 1986. That was a rewarding experience for those youngsters, who could not believe they could shake President and Mrs. Reagan's hands and meet all those high-powered people. One child said to me, "Mrs. Bullock, I don't know if I am going to wash my hands for 2 weeks because I shook the President's hand and I want to remember that."

So those were memories of our Just Say No clubs. But Just Say No is never going to do it alone. It is a public campaign, an awareness program. But if we think that that program is going to do more than just create an awareness, our expectations are unreal.

When I started the clubs in Baltimore, I recall going to principals and seeing the little yellow packets, "Just Say No." They had cute little kids on the front, and they sat on the principals' desks because the principals really did not understand the concept. They did not know what to do.

There had to be somebody to coordinate prevention activities. I believed in that process. I did not want the Just Say No club to be just a media campaign. I wanted it to go beyond that in my school system. I believed that we could take that project and move with it and effect some change with our youngsters toward developing positive behavior. So I asked some people to help me. I went to Zeta Phi Beta Sorority, whose members I knew had a community outreach project. I asked them to sponsor about 30 to 40 schools that wanted to start the Just Say No clubs. They were willing to provide $10,000 because they were committed to that project. And Zeta Phi Beta Sorority provided not only financial support but human support as well. They were in the schools. They worked with the staff

physically to help with bulletin boards, to provide materials and audiovisual equipment, and to do whatever those coordinators needed. That sorority was there and its efforts were well received.

But when I looked at the Just Say No materials and pulled together all the things I needed to implement that program, I felt there were some weaknesses. The bottom line is that this club concept does not replace, supersede, or change anything that exists in a comprehensive K through 12 program. Comprehensive programs are programs in which youngsters get formal instructional activities at every grade level, noting the age and maturity level of those youngsters. Primarily, I felt that to "just say no" is not easy even for adults. Can we expect young kids to say no to their best friends who are experimenting with drugs? These are the people with whom they have grown up and shared lives, people whom they trust. When such influential people begin to experiment, is just say no enough to deter their best friends' involvement?

So I incorporated a series of strategies into the project. I trained the coordinators, who would act as advisers and facilitators for each club, on implementing these strategies, and it was very effective. We spent time in having open dialog and discussion and in helping kids learn how to say no. "Saying no" is a skill that has to be practiced. How does one say no and mean it? What is body language? What is voice tone? How does one practice these skills? That is a large component of that process, and we have to reinforce these skills and help kids practice.

How was that program evaluated? At the end of each year, those youngsters who were involved in the Just Say No clubs were given opportunities they felt they could not have gotten before. They were given extracurricular activities, such as skating parties, and the key to the whole thing was to have them involved in the planning. Kids said to us, "I do not want to have a regular, structured classroom activity. I want this to be fun and if it is not fun, I do not want to be a part of it." And at the end of the year, they said to us, "I enjoyed it and I was able to do some things. I went bowling. I was able to talk. I learned strategies that I did not know before." They had their own little codes to use when they met their friends in the hall. It made them feel special and raised their self-esteem. These are affective areas, which are difficult to measure. We can easily measure knowledge, but in the affective domain we have to deal with changed attitude and then behavior.

The next year the clubs grew. That was another sign that we were successful. Kids were at the door asking to be a part of it. But the members set the guidelines as to who belonged and what codes they wanted for behavior. One principal said he saw a change in his school because kids were so eager to be a part of all of the fun things. The White House trip was also a motivating factor for many new members. So it had a positive effect. By the third year of this project in that

school system, it had been a successful, well-received experience for all. Thus our expectations can go beyond the realm of that youngster's knowledge when we say "just say no"; the program provides an excellent awareness activity.

What are some other prevention programs? Project Smart is a model that was developed in California, and we have it in every school district in Maryland and across the country. It is designed for youngsters, grades 6 through 9, and it includes teaching peer resistance skills, teaching kids how to say no, and giving them the strategies. Above all, the program provides information about AOD use and its dangers, and it emphasizes decisionmaking strategies, whether the subject is drugs, sex, or whatever. It is important for kids to have information so that their decisions are based on good, sound information. This program has been researched and evaluated, and is effective for some students.

Furthermore, any good program must have a well-trained teacher-trainer component to make teachers feel competent in delivering such a program; otherwise, they will not be able to implement the program. In Project Smart's training program, teachers receive everything they need for those 10 lessons in AOD use.

Another project is "Here's Looking At You 2000," a K through 12 model. It is nationally known and has a series of strategies. It also has a parent component, which is another important ingredient. If there is no component for parents in any of these programs to provide workshops for parents to know they are involved in this whole process, or if there is no take-home piece so parents know exactly what is happening in the class, success will be harder to achieve.

"Be Smart, Don't Start, Just Say No" is another media campaign. It is an awareness program. Beyond that, it involves the community in creating that awareness and it has been successful.

The "National Quest Skills for Adolescents" is another program designed for middle schools. It is very important in this program to deal with self-esteem and decisionmaking. The program does not focus primarily on AOD use, but once we provide those skills for youngsters in whatever area, we can effect some change.

"It's Me, Drug Free" is another media campaign that works well in an awareness area and very closely involves the community.

There are many other good models, too. However, there are key things that every good prevention model should have. First, it must be comprehensive: it should focus on elementary, middle, and senior high schools. It must offer formalized instructional activities. It must provide a teacher-trainer model with more than just 1 hour of training. In many of our teacher-training models, there are 24 hours of training. Many of those models are residential: teachers or students go away to where they have to spend 8 hours or more per day working

together. "Here's Looking At You 2000" and the "National Quest" programs provide teacher training. They are not cheap programs, but they have been effective. Project Smart, of course, provides the same. Some models require consultants to come in to work with groups.

These national programs are good, but we also need to look at the uniqueness of our community and develop curricula that are relative to the needs in any given community. Moreover, unless we have a strong community involvement in all aspects of preventing drug use, we are not going to get the changes we would like to see. This involvement means the participation of not only the political forces in that community but also of the regular citizens. In this respect, it is important to have parental involvement. If there is a drug education advisory committee, parents must be involved. We have to touch all bases and have all aspects of the community working together. The key is working together.

In 1986 the Federal Government provided funds for the first time to every school district. In my district, Maryland received over $2 million, of which $1.6 million went directly to the school system. That was the beginning of the Government's commitment. It was not enough, but it was a commitment to say that we need to live drug-free lives and we need to effect change in a positive way. It is just a beginning.

It is a hard task. It is a long task. Sometimes we do not see success at all, but we have to keep plugging at it. If we believe in tomorrow, if we look at the future generations of our Nation, we have to begin with our youth.

The other issue is that we know that billions of dollars were invested in treatment and intervention strategies. They did not work. So the key is to look at prevention. Cut off the demand. Then that will have some effect on the flow. We have to do that from inception.

Ms. Chambers: I want to start with the Just Say No club.

I was asked to make a presentation on Just Say No to a Head Start class of mostly 3- and 4-year-olds and to tell them about drugs. I had been doing this with older kids, which was okay. But now I said, "Don't be ridiculous. What can I tell those little kids? They don't know anything about drugs. I mean, they aren't interested in any drugs." Still I was told, "Go ahead and do it."

In fact, I was shocked. These 3- and 4-year-old tiny tots were telling *me* things about drugs. They even got to telling me what was happening and what types of drugs were being used down the street, two or three doors from them at so-and-so's house. They told me things that made me sit back.

I can't say too much about Just Say No because I feel that in the long run it is going to pay off. Whether it is effective cannot be measured right now. We do

not have any way of measuring it today. But we are hoping it will prove to be a most profitable exercise in the future. You should hear the enthusiasm with which some of those little kids can say, "Just Say No!" And if they are not serious, they sound as if they are, and if they keep saying it enough, they will brainwash themselves. We will not have to do it.

I think it is important that we start with these very small people. If we wait until a kid is in the sixth or seventh grade, it will be too late. Many of these kids have already gotten started on drugs. Statistics prove that.

At this point, instead of relating my thoughts about "Project Options" and the media in education, I would prefer to discuss some of the young people I come in contact with and try to express some of the thoughts they have shared with me, because they are the ones who this is about. I have passed the stage at which I would be getting into drugs. But the younger people are the ones who are out there vulnerable, looking around, trying to see what is happening, what is going on, and what looks good. This explanation is what is important to them.

I asked a group of young persons between the ages of 14 and 25 how they individually felt about the media and education. Most felt that any education related to drug use should be more graphic, like the "Scared Straight" program or films they had seen when taking driver's education. They said pictures of victims of an overdose, pictures of users who were crippled or maimed, or even pictures of those who might have self-inflicted wounds are something more young people need to see so they can see how horrible it is. If they do, maybe they will not think it is so great to take drugs, and when someone says "try it," they will not.

The announcement of the street value of certain drugs creates a vision of instant wealth, gold chains, fast cars, and costly clothes. The youth felt there should be more pictures of dealers, suppliers, runners, and the like being arrested and stripped of all of their ill-gotten gains.

They admitted there are often excellent public service announcements about drugs on television and in print, but these are too short and are not shown often enough. For example, they liked "Users Become Losers" and "For the First Seven Years of His Life, He Didn't Have a Father." But they felt these should be shown when cartoons are being shown or when advertisements are being aired for the new toys that should be purchased for Christmas. Similarly, "Don't Do Drugs and Be a Junkie" should be spread through children's funny books. Since youngsters can and do get involved with drugs at a young age, Just Say No clubs and the planned use of leisure time would also help.

Many of today's kids have too much time on their hands. Children do not have chores that have to be done. Many do not know what it is to wash dishes and

make beds or pull the house together before mom comes home from work. So they have all that extra time.

Music is supposed to soothe the savage breast, but it also impresses the young mind. Sometimes the beat is so inviting that listeners are moving, tapping, and shaking their shoulders in harmony with the music, completely unaware of the full implications of the words that are being said or suggested. The words are often inviting them to join in with the psychedelic, funky, cool people; to sleep together; to smoke pot; to drink alcoholic beverages; or to shoot up, free-base, or snort up.

Billboards stretch from coast to coast, from Canada to Mexico, and many portray how a person can relax on a long cigarette. Calendars advertise how smooth a certain drink goes down. Magazines show the smart dressers, often with a cigarette or drink in their hands. And many little girls and more little boys who want to be cowboys or cowgirls see these advertisements that usually show cowpokes on horseback with a drink or on their way to get their trusty cigarettes.

I am not saying that the media haven't done anything. They have done a lot. The youth I questioned liked most of the different, catchy Just Say No spots. But they figured the media could do more. They felt that many times the magazines send out a dual message: on one hand, enjoy anything as long as it is enjoyable but, on the other hand, certain things should not be done.

I first got into the Just Say No project and drug prevention when the community decided we had what was considered to be one of the worst corners in the United States for the open passing, selling, buying, and using of drugs—the corner of Clay and Washington Streets in Annapolis. It was a busy corner, and not just because of the people who lived there, either. There would be strange people standing there and other strange people coming there. We decided this situation was not what we wanted for the young people in that area.

We became rather frustrated with the situation on our corner and we came together in a group. Some were parents. Some were persons in politics. Some were from various organizations. We formed a group called Planning Action Committee, or PAC. We invited approximately 35 or 40 different organizations and companies and any kind of group we heard of. About 27 of them sent representatives. Not all the representatives met together all the time, however; it depended on who could get there at a particular time.

By brainstorming we tried to come up with some ideas to alleviate the situation. Someone in the group asked why we weren't involved in abusing drugs ourselves. Drugs were around 10, 15, and 20 years ago. Why didn't we take them as our companion and friend? As one female user told a fellow, "You have only one friend, and that's the white dust that goes in your nose." That is their best

friend. Why wasn't it ours? And our answer was that most of us were busy. We had chores to do. We had to do our work at school. We just did not have the time to fool around.

I saw the most excruciating thing I have ever seen when I was working in a building with the youth. A janitor called me over and said: "Hey, Miss Chambers, come here. I want to show you something." I went over to see what it was, and he said, "Look right outside the window." So I stood up on the side of the radiator and leaned way over and looked. With all that we hear about AIDS and drugs, there were a man and a woman fixing the syringe. The woman was carefully looking everywhere for a place on her body to put the needle. Oh, she was searching. I had never seen anything like that before in my life. Finally, she went down to the front part of her ankle, and this is where her companion helped her put this needle. Then he turned around and he used it. I just stood there appalled.

Our kids have been seeing this type of thing, which is why we have continued to work. Sometimes we only have 8 people out of the 30, sometimes only 5, but we continue to plan. We feel that if we give the kids something to do, something they can feel positive about, we are helping.

Self-esteem is one of the areas in which we are interested. Everybody wants to be seen at one time or another. Every kid wants some type of recognition, whether or not they say it or act like it. We often say to kids, "Sit down, I see you," which is something they want. They feel it is a terrible thing to go through life and nobody knows they were there. Thus, if they can be recognized for doing something positive, they may not be so prone to get into trouble. If they are happy, if they are where someone thinks they should be, these young people are going to do so much better.

Children also need to know themselves before they can deal with other people. They need to know themselves pretty well and many of them do not. And many need to have more positive role models to emulate.

To deal with all this, we came up with a little program we call Project Options. Project Options is trying to move young people toward a slightly different lifestyle by helping them become motivated, able, useful, responsible, educated, and amiable. To engage groups of young people so we could have someone with whom to share our information, we contacted the youth centers, the churches, and every other place we could think of where kids might be, and this is where we have taken the program. But first we made sure to train other people because we cannot do it all. We used a lot of little booklets that we use with the kids so our personnel could have quick information.

We selected three areas to work on to help us reach our goals: self-awareness, career awareness, and drug awareness. To work on those areas, we use a lot of

different materials. The first thing we start off with is the Myers-Briggs Type Indicator. It is simply used to help people find their personality type, the facts about the 16 basic personality types, and where they fit. They learn it is all right to be different. So often kids are made to feel that they are not all right. People who love them make the mistake of saying, "You are just like your daddy" or "You are just like your uncle," and that is the person who does not do anything right. So mommy is telling you you are just like him. How much value is that putting in your head? How do you feel about yourself then? So we give this measure and the kids find out they are all right, but if there is some failing, they can improve it. They learn that they are the only ones who can bring about good change.

We also use booklets. One of the simpler types of books that our youngsters seem to like is about career finding. It is fun and colorful, and they enjoy it because it requires little writing. Another booklet deals with attitudes because attitude makes a big difference. A third is about self-esteem, and a fourth is on decisionmaking.

These are some of the areas in which we feel they need strength. We also use some of these same areas in our Just Say No group for the larger kids. We even try to deal with assertiveness—how to look someone right in the eye and say, "No. I don't care for any."

We also do lot of the things everyone else does. There are several very good films that can be shown to kids. We have shown the "Wizard of No." I do not care how many times kids are shown the "Wizard of No"; they like it every time.

After we take them through these areas, we feel they have a better understanding of what they are about. Then when we end our program, the last thing we do is give them a poem that we feel tells the whole story. The poem is called "You," by Edgar Guest. Briefly it says that the individual is the one who has to decide.

This is our Project Options. We cannot say much in the way of evaluation yet because it is too new. We really do not know yet. We are still presenting these workshops, and we basically do them in 2-day seminars. Then on request, we go back for elaboration of any area that might be of interest to them, which is our Options program.

I also want to describe two other programs quickly. One is "For Kids' Sake."

We had a school that was in the news and it received unfavorable press. These problems led to a court case. Public relations were not as they should be, and trust had been lost. As a result, a special program was started in that school last year. It has not finished a full year yet, but so far it seems effective. As part of it, two part-time community school liaison individuals go to the students'

homes to help bridge any communication gaps with the school. In doing so, they have found a lot of things.

For instance, they found that some parents who would not send back any materials could not read and did not want other people to know. One of the liaison persons asked, "Was it that you had difficulty in reading and understanding the material that came in? Is that why it didn't come back?" The parent answered, "That's just what it is," and she immediately gave the liaison person all of the information needed. The liaison person wrote it down and the parent signed it. This helped solve the problem of communication between the school and some of the parents.

"For Kids' Sake" has exposed the kids to different experiences such as games, trips, cultural affairs, and activities, which seems to be bringing about a much better use of leisure time. We are hoping that it, too, will prevent drug use because the kids are being taught many skills in the evenings. On Mondays, for example, they do various things in the performing arts. If a kid can get on that stage, front and center, with everybody looking, he or she does not need to do drugs. He is a big man, anyhow; she is a big lady.

Finally, they have started another program similar to Project Options, for a group of afterschool youth in the same neighborhood about which I spoke earlier. The afterschool program operates from 3:00 to 5:30 p.m. and it helps the youth with homework. They have various clubs for the kids, and they try to give the kids positive things to do. We hope that this program becomes an asset to these young people, and that they, in turn, will become an asset to their community.

Ms. Tobias: I am a nurse. I taught Lamaze natural childbirth for 10 years. I am also the mother of seven children. Right now, their ages range from 12 to 25 years old.

My first five children were born within 6 years, which makes for a pretty close family life with not too much time left for parents to go out partying or anything. As we raised our children, we really had a good time. We did a lot of family activities like camping and bike riding. A lot of weekends we could be found on a towpath, my husband and I on our bikes with a child in the front, a child in the back, and one on the back pack. That is how our life was spent.

When the children entered grade school, they became active in sports. My husband was involved in coaching, and all our weekends were taken up with from four to six soccer games, swim meets, and so forth. My last baby went to his first swim meet when he was 12 hours old. Clearly, I did not miss very many of their events.

But along about the time that my two oldest children, who are boys, were about 15 and 16 years old, I found I did not like my job anymore. It was not fun

anymore. Furthermore, our two oldest boys were acting rebellious. At first I thought that this was normal teenage behavior and that I should expect it. That is what everything I read told me, and I had always heard that adolescence is just supposed to be unpleasant.

But one day, I walked into one son's room and caught him stuffing a bong—an apparatus used for smoking marijuana—under his mattress. That brought things out in the open, and then I knew why I did not like my job anymore. Things became a little more clear.

When I discovered this, I was pretty devastated. I was upset. I was angry at them. I was scared for them. I was scared they were going to die, and I was afraid they were going to bring all the rest of my children into drugs. I figured they were close together and drugs would just go right through the family.

I was scared straight. We tried to deal with this problem but nothing worked. We took on new forms of discipline, but still nothing helped.

The boys were not a problem at school. They were getting A's and B's in subjects like Advanced Chemistry and Calculus. They were excellent students, the whole bit. They were also varsity athletes. Nor did they look like druggies. They looked nice and neat.

We reached the point at which we had the kids so restricted that the only places they went were school, work, and home. We finally figured out that they were getting drugs at school. It did not seem as if there was any other place they could be getting them.

I read an article in the *Washington Post* about a group of parents in Atlanta and another group in Florida who had the same thing happen to them. They had formed what they called a parent group or parent peer group. They called the parents of their kids' friends and told them what they had discovered. They suggested that the parents group together and try to see whether they could do something about their problem.

My husband and I decided to try that. We talked to some of the wrestling parents, but none of them had a problem; only our kids did. In fact, they *liked* their kids to go around with mine because mine had the good grades. So my husband and I started doing a lot of reading and gathering of statistics. We took this information and our idea of the parent group to our high school principal.

I did not realize it at the time, but now I believe the idea was divinely inspired. This principal said to us, "I can't handle this at school. I would love to have help." At the time, I did not know how unusual he was, but now I do know. I know that no other principal in Fairfax County or probably in almost the whole United States would have given me that response because school principals are just like parents. They are in deep denial, and they consider a school with drug problems

a reflection on their job performance, just as parents consider themselves failures if their kids get into drugs.

I was very fortunate that this man was not in denial. He said, "I would love to have help from you. Let's go to the PTA and see if we can convince them." Much to my surprise, the PTA bought the idea. It was probably the only PTA in the whole area that would have, and it gave us the green light to go ahead. The PTA said it wanted us to be a group separate from the PTA, which is just what we wanted, but it agreed to finance a mailing.

I wrote a letter to all school parents, giving statistics and ideas on what we could do in our community. Again, much to my surprise after being let down by the wrestling parents, the day after I put this mailing in the mail, my phone rang off the hook. This was in 1980. I had fathers calling me saying "Thank you, thank you, thank you; finally somebody is going to do something."

At our first meeting, 120 parents who really wanted to do something showed up. We had signup sheets for committees and we presented ideas. Hope is what I think we gave them. We formed a steering committee, which became our board of directors. Within 6 weeks we had bylaws written; we were set up and collecting dues. There was a lot of seriousness in this group. Parents were fed up.

The biggest concern of the parents was trying to get the school cleaned up, but we immediately realized that we were totally ignorant on this subject. The first thing we had to do, then, was to spread awareness and to educate parents. We have been doing that ever since. We found we could not do anything if we did not know what the score was. It was not until this past year that we ever got to the kids.

A school committee was formed that was composed of a lot of angry people, myself included. We were all doing a lot of blaming. But we realized blaming would not get us anywhere. We could not solve this problem by blaming. We had to recognize that we all had a role to play and that nothing would happen until we each did our part and started to work together.

Three of the fathers got together and talked with the principal. We found out what his problems were and that there were a lot of reasons why he could not do things we thought he should do. He already had all kinds of ideas on what he could do if he had parental help. We learned his side of the story, and he learned our side.

This was in April, near the end of the school year. In June our principal was put on a sabbatical. As it happened, the message got up to the bosses quite quickly, and there was a lot of fear within the school system that this parent involvement might spread to other schools. That is how the bosses decided to

handle the situation; however, they did send us another, very strict principal, who cleaned up the school quite a bit but with no parental involvement, which was okay because he did a good job.

But as the new school year went on, we came to learn that there was only so much the principal could do because he did not have the backing of his superintendent. If there was an incident in which the parents went above the principal, the principal's superiors tended to favor the parents who were trying to bail their kid out of trouble. That time was when I realized that I could not just clean up my school until strong regulations came from the superintendent.

Meanwhile, a lot of us were putting our kids in treatment, at which point our kids started talking to us and we learned about the real street scene. We were shocked at what our kids told us they had been doing while we had been carefully keeping track of them. They had always been outsmarting us, no matter how good we were as parents or how neglectful we were. We also learned how they got by with this in school. Of course, they play the same tricks at home.

I made a questionnaire for some of the kids to write stories telling how they managed to do drugs in school and get away with it. Out of those I got about a dozen stories that gave me the facts I wanted, and I sent them to the school superintendent and asked that we meet. He called me right away, we met, and he appointed a task force to study the problem. That task force recommended a set of good school regulations that had teeth in them and that were not aimed at getting kids expelled from school or putting them on the streets; instead, the purpose was to bring families out of denial and get the kids into treatment. The school board approved the recommendations.

The program was presented at the White House and it received a lot of national recognition. But it only happened because some parents had guts and took a lot of risks. I had to go to politicians to get this going. There was a lot of behind-the-scenes hard work.

I believe drug education will not do any good unless the kids see us also enforcing the rules. They are getting a contradictory message if we tell them that drugs can harm them but they then learn they can get away with doing them at school and there are no consequences. They con school people just as they con parents, and we must be smart enough to see through their con games and recognize that they need help. Otherwise it is as the kids continuously told me, "The school people don't care. They just always look the other way." That is how they interpret our ignorance. Therefore, drug education is not effective, as far as I am concerned, unless there is the other component.

That case also exists with the media. If television, for example, does all the "Just Say No" campaigns but then shows other programs that give kids the message that "it's okay to do drugs," we can forget it. Children must get the

same message from all of us, and they must get it at home, at school, through the media, at church, and so forth.

The Parents Association to Neutralize Drugs and Alcohol Abuse (PANDAA) has been involved in a lot of things since 1980 besides just working with the schools. We also developed a court watch program, in which volunteers observe the drug-related felony cases in court, record the statistics, and publish them. We find that there are really no consequences for dealing drugs. Drug dealers rarely see the walls of the jail, and if they do, it is for an extremely brief time. We believe there should be consequences for dealing drugs. We also pressure for drug rehabilitation of offenders, whether they be users or dealers. Actually, today almost all dealers *are* users.

Our PANDAA newsletter is one of our big activities. It is an educational endeavor. When we started out, we found that we were all really stupid. Whether we were nurses, doctors, alcohol counselors, or any other professional, our kids conned us and we didn't recognize it. We were in treatment with people who were in the counseling field, and we all had been conned by our kids for years. So we started doing awareness programs. However, we would get only 5 or 10 people to come to them, which is still true. I became frustrated at how much work these programs were, and I finally decided that if I could not get the parents there, I could get the literature into their homes. So I began this PANDAA newsletter, and the principal gave me the mailing list for the whole school.

The newsletter went to every family in the school for a couple of years, and since then we have had a large enough membership to pay for the printing. We print 7,000 copies now and we send them to all State delegates in Virginia, to our local politicians, to treatment programs, libraries, pediatricians, and to every school in Virginia. We distribute it for free quite intensely. It also goes all over the country and to several foreign countries. So it has been a very well-known piece of literature in this field, and an effective tool that pulls everything together on what we are doing. It also gives us a lot of influence in the community. The printed word is extremely powerful. If people can get it disseminated, it gives them a lot of credibility.

When we first started, the professionals, like the school people and the court people, were leery of us, so we had to build our credibility. After 8 years we now have a lot of credibility in the community and a lot of influence, but that is only because we stuck to it. We have proved ourselves with time.

We also have a "listening ear" service for parents. Parents can call and talk about their problems anonymously. For many, it is the first time they have even said out loud that they suspect their child of doing drugs; it takes a lot of courage for them to do that.

Last year, we published three books that tell about all our activities. One book, *Kids and Drugs,* gives all the information anybody needs to work in this field. We mail this to all our parents who call with a problem. This book is also the most frequently mentioned resource in the book *Schools Without Drugs,* which is published by the U.S. Department of Education.

This past year was the first time we did anything with kids. We took a busload from five different high schools to the PRIDE Conference in Atlanta, GA, which is an international adult and youth conference on drug use. The kids received leadership training and peer-counseling training. We hope to do it again this coming year.

We hope we are knowledgeable enough now to start doing more things with kids, and to keep going.

Dr. Ford: "An ounce of prevention is worth a pound of cure" is an ageless adage. However, in addressing various problems and ills within our society, we have a tendency to be crisis and treatment oriented rather than to identify etiologies and concentrate on primary intervention. Although it is necessary to be able to attack problems from a variety of perspectives, experience and common logic tell us that it is much more efficient to emphasize prevention.

The Howard University Drug Education and Prevention Program (HUDEPP) is designed to focus on primary prevention by using the peer interaction approach. The Fund for the Improvement of Postsecondary Education (FIPSE), a division of the U.S. Department of Education, awarded the University Counseling Center a 2-year grant to develop a campuswide, comprehensive AOD education and prevention program. The major purpose of the program is to provide an array of education and prevention activities that are based on an understanding of the unique needs of Black students attending an institution of higher education in an urban setting.

HUDEPP officially began in September 1987. The specific objectives are oto determine, to the best of our ability, the full extent of drug abuse among Howard University students.

- to establish a highly trained cadre of prevention workers, including residence counselors, campus pals, and other peer educators.
- to provide a vehicle through which students can develop innovative education and prevention activities, programs, services, and materials geared specifically to Black college-age students.
- to provide university faculty with the resources and support necessary to incorporate information on AOD abuse into the very fabric of university life—the classroom.

- to establish a forum through which experts and students, faculty, staff, and people from the broader community can learn about and share information on drug use and abuse.
- to develop a directory of experts available to address student populations from the elementary to the postsecondary level on AOD use and abuse.
- to provide a 24-hour drug information telephone line, which will include a schedule of drug education and prevention activities planned on the campuses and in the Washington, DC, metropolitan area as well as a list of treatment resources in the area.
- to promote and create a campus environment that will have as its norm a prevention message AOD abuse deters the ability of the Black community to develop leaders.

In accordance with the task of determining the incidence of AOD abuse patterns, a revised Washington Area Council on Alcohol and Drug Abuse (WACADA) questionnaire was used to ascertain the incidence of use and to assess the students' perception of drug prevention efforts on the campus.

The HUDEPP staff met with the Howard University Division of Student Affairs and coordinated and organized student representatives from various groups throughout the campus (sororities, fraternities, State clubs, campus pals, resident assistants, graduate assistants, and so on). These student groups serve as the impetus of this program because students are often more responsive to their peers. Using a variety of incentives and monetary rewards, these groups are encouraged to sponsor drug education and prevention activities with the assistance of program staff.

A peer-training workshop took place on January 22, 1988. Representatives from student organizations, graduate assistants, and residence counselors and residence assistants from the various dormitories attended the workshop. The participants received information and training to help them become more effective peer educators.

The week of March 7–11, 1988, was designated "Drug Abuse Prevention Week." The focal point of campus activities for this week was the ground floor plaza in the university's Blackburn Center. Students displayed exhibits and activities designed to get across the message that AOD use is not acceptable.

Additional tasks that were undertaken included the following:

- development of an AOD prevention kit to be made available to health education instructors and disseminated to students.
- development of a drug prevention module to be incorporated into the Health Science curriculum.

- coordination of colloquia by expert authorities on AOD use.
- development and dissemination of drug information using a multimedia approach.
- formation and circulation of a Speakers Resource Directory.

The college population, and Howard University in particular, may not be viewed as a practical location for a drug prevention program. However, it is in college that many persons experiment with drugs for the first time or expand their drug use. The additional stress, the new-found freedom of students experiencing their first taste of independence, and the transition from adolescence to young adulthood are factors that may result in AOD use.

The ultimate goal of HUDEPP is to serve as a clearinghouse of drug information for the Howard University community and to create a university-wide norm that considers the abuse of drugs detrimental to the growth and potential of students as future professionals and leaders. Above all, we hope to contribute to the creation of a drug-free environment at Howard University.

Prevention Models for Black Youth at High Risk: Industry and Government

Participants: Mr. Charles Avery, *Moderator;* Ms. Artherine Rullow, *Co-moderator;* Dr. Alice Murray, Dr. Terra Thomas, Mr. Dennis I. Nordmoe, and Mr. Peter Edwards, *Panelists;* Mr. William Burrell, *Recorder.*

Mr. Nordmoe: Prevention is a complex topic. If you reduce it to a simple plan of one or two simple programs, you can communicate all about it. But as soon as you get through, people will start to get uncomfortable. They will say, "Well, but you're neglecting this, you're neglecting that," and so on. Conversely, if you keep it complex and lay it all out for people verbally, they get impatient because it is too involved.

The causal model we use guides our design of intervention plans. It assumes that individual and family factors, family history, family management problems, parenting issues, family religious tradition, and friends who use drugs are all factors in the web of causation. Also included are community factors such as community norms, which Peter Bell often talks about, and the proliferation of retail alcohol outlets.

In addition, the system of law enforcement regarding sales of drugs, juvenile crime, and ineffectual community institutions at every level—including educational, religious, and recreational—are all factors in our comprehensive view of what places people at risk.

There are also systemic factors—for instance, the role of employment opportunities, the welfare system, tax rules that keep alcoholic beverages relatively cheap, public school problems, and the media. Although we may feel these issues are beyond our control, they must be acknowledged or people will think we are speaking without understanding. These factors all influence individuals, and those influences, combined, have various outcomes—not just *chemical* dependency, but unemployability, teen pregnancy, juvenile delinquency, and academic failure. Recognizing that those other outcomes are part of the picture helps to develop a coalition, a community base, that is concerned with the various problems that share risk factors.

Our basic intervention strategy is to strengthen the healthy behaviors of and the influences on the person who is making decisions, and to impede and weaken the negative ones.

On the positive side, we are concerned about better education and all that that involves—school policy, finance, and parental support. We are also concerned about making family life stronger, resolving unemployment, and

reducing transportation problems. If religion is a factor—and the research says it is—we are concerned that so many young people are totally untouched by religion; therefore, the effectiveness of churches as churches is relevant. And the positive uses of leisure are an issue.

On the negative side, the accessibility of drugs, the status of the criminal class in the community, sentencing, and the availability of correctional facilities are all factors that have a detrimental influence on community norms.

Therefore, if we can strengthen all the positive forces and at the same time place barriers on the negative ones, we will increase the probability that the individual will make the kinds of decisions about drugs that will be healthy.

How do we plan prevention programming to achieve all these wonderful objectives? The traditional approach to planning programs includes (1) developing a proposal, (2) getting a grant, (3) engaging subcontractors, (4) implementing the program, and (5) evaluating the program. Then the bureaucrat says, "see, we helped 37 people. Now, give us 200 times as much money, and we will help one-third of the entire population." The summary statement is "we need more money."

Perhaps more money is allocated. Then, 5 years later, the community says, "Well, we gave you all that money, but the drug problem is still here." The prevention administrator retorts, "Oh, but surely you didn't expect us to handle it all ourselves. Don't you recognize the roles of schools, churches, employment, transportation, and so on?"

Because we know all this to begin with, why don't we admit it and incorporate all those elements into our prevention planning?

Or perhaps what it takes is an entirely different approach to planning. It means starting off with a comprehensive plan, such as the one we have developed in Detroit—a plan that lays out a role for every agency and every group in the community. It means trying to get things moving simultaneously on all tracks. To me, the ecological approach means that the individual makes decisions in a network of influences. Thus, if there is a behavioral problem in a population, the change agent must get things moving with the schools, the community organizations, the churches, and the parents' groups simultaneously. These multiple positive community changes will lead to outcomes that include healthy individuals and stronger families.

The first challenge, then, consists of motivating and focusing community leadership. The plan behind our model and programs in Detroit is to show the community the part it can play in the effort. Our plan is not just something the Bureau of Substance Abuse can take full responsibility to implement. Thus, it is important to lay out in the community plan all the expectations of its various

sectors and institutions. This action enables community leaders to recognize that each agency and group has a role to play. It also helps to develop an ideological consensus so people can agree on a comprehensive model.

We have tried to dramatize the depth and extent of risk factors for alcohol and other drug (AOD) use with our report on Detroit youth. It takes seriously what David Hawkins and Richard Jessor have told us about such risk factors, and it asks, "What is the status of Detroit youth on these various risk factors?"

That report has been circulated among the leadership of our community—Federal judges, city judges, the board of education, the superintendent's cabinet, the city council, and so on—and has helped develop recognition that we have a serious youth problem. It is not just an AOD use problem, and a separate teen pregnancy problem, and a separate juvenile delinquency problem. It is instead a youth problem that is so profound, so serious, and so extensive that about half of our younger generation is seriously at risk for using drugs.

To accomplish a great deal with only a few dollars, then, we must be careful to spend that money to gain maximum impact. One thing that can be done with limited money is training. We have provided training in two areas: prevention program development for neighborhood leaders, and AOD treatment counselor training for protective services workers and mental health workers.

We are developing a culturally specific curriculum for urban parents and a curriculum for training the trainers. We plan to make that training available at low cost to volunteers from unions, churches, and community groups and to assigned staff from mental health centers, schools, and social service agencies. Our drug treatment counselors are already receiving parent training so they may pass these skills on to their patients.

We have on the planning board right now training in wellness programming. We have also provided intervention training to clergy and social workers.

We have created an efficient and low-cost mechanism for training by using the section of our local State university that is already set up to do community training. It is called the College of Lifelong Learning, and it routinely does extension work. Because the administration and marketing systems are already functioning, we do not have to pay to develop those services. Thus we put $35,000 into that program last year and trained several hundred people with very little staff effort from the agency. We paid for Detroit people on a scholarship basis so we could target who received the training. But there were so many people who thought the training was valuable and were willing to pay tuition for it that the total cash flowing into the program amounted to $67,000. We hope, with the addition of grants, to bring that up to $200,000 in a couple of years and to have an impact on the entire community. If we achieve that goal, these at-risk youth

will receive multiple community and agency influences reinforcing the same AOD use prevention message.

We are also working in the area of community organization and enablement. Our Education for Prevention in Communities (EPIC) program was created under contract with the Addiction Research Institute in the Department of Community Medicine at Wayne State University Medical School. Its purpose is to offer authoritative information to community groups on how to prevent drug use. EPIC staff members have master's degrees in public health. They work in assigned neighborhoods with clergy, community leaders, local agencies, and block clubs to help develop grassroots programs for prevention.

We have done something else with churches. Some clergy came to us and said, "Some days, the only sober people we see are those in the AA group at our church. The families of the children whom we go out to visit are intoxicated. If the city would assign an interventionist to work with us, we think we could accomplish something with these families."

It sounded like a very good model. However, often, we talk about the importance of the churches in the community, and then we say that their role in AOD use prevention is to carry out a public health message. However, the literature on risk factors suggests that religious involvement itself is a prevention method. Perhaps if the churches were more effective in fostering religion, some of these other prevention methods would not be as essential. We cannot provide support to religious activities. However, we have learned to emphasize local prevention program development over casework, and we are now adding two more groups of churches.

This situation suggests another point. Government intervention itself is not going to solve all the problems in our communities. Some of the most profound problems are simply beyond the sphere of appropriate government action. However, public leaders do need to identify the prevention roles that private systems can play and to communicate to those systems about their roles. This effort may include helping people begin to look seriously at what is going wrong in the private sector and challenging them to come up with winning solutions.

Community education is another of our areas. The Michigan Model for Health Education is an excellent program, well on its way to becoming a standard part of our curriculum for the elementary level. It incorporates AOD problem education in each year's program. We have also financed the creation of "Which Way," a drug education program for middle and high school youth. It is available to schools on request.

We contract with KABAZ, "The Black Jewels," a Black drama troupe, which takes the message of drug prevention to the schools. This year, we are asking our drama troupe to concentrate on the value of education. We feel that, with a

58-percent dropout rate in Detroit's schools and with those who do stay until the 11th grade scoring 2 years below national norms in mathematics, we are creating a generation of young people who are going to be unemployable and, therefore, particularly at risk for drug dependency. They are going to be sitting around, trying to figure out what to do with themselves. They are going to be embittered, and they are going to be looking for some excitement and meaning in their lives, wherever it can be found. They are going to find that excitement in AOD. Thus, we need to get our youth to take education seriously. Not only have we asked our drama troupe to put aside its exclusive emphasis on drugs and talk instead about education, but also our parent education program will include a section on parenting for achievement.

We would like to have a media project. We do not have that now but it is a part of our plan. We had $50,000 left over at the end of the year, which we used to purchase 500,000 pieces of literature. The public health clinics, the libraries, the public pharmacies, and so on have distributed those quickly. We are now working with our public library system to create a more orderly and continuous flow of information on AOD problem prevention and intervention topics.

We have had an athletics project and a seminar to bring role models into direct contact with community youth to talk about some issues that affect them.

We have taken a vacant health center and turned it into what we call a youth empowerment center. It is a community recreation center with a prevention emphasis run by a prevention agency.

Earlier, I mentioned parent education that is being carried out in several ways. We have one contract to concentrate exclusively on parent education for the highest risk parents. This year we are also requiring that all our treatment programs perform parent education with their patients whose children are at risk.

We are trying to be age-specific in our strategy development. While alcohol, cigarette, and marijuana use constitutes a significant prevention target among teens, young adults in their 20s are also beginning to make serious decisions about drug use. Very few of our drug deaths or treatment admissions occur among persons under 25 years of age. We have not formulated any serious prevention intervention for the young-adult age group.

Our prevention plan also addresses political issues. If our schools are doing poorly because of the way our tax system is set up, comprehensive prevention planning requires that a place be made for tax reform on our prevention agenda. In Michigan the amount of money a district has to work with per pupil depends on the amount of industry within its political boundaries. That system is bad for us. It means that the youths who need education the most have the least spent on them. A community coalition called "New Detroit" is working on that

issue. A community movement is growing in Detroit to make the schools accountable for producing better students. Its success is very important to our prevention plan.

On a smaller scale, our prosecutors in southeastern Michigan have put together a competition based on the Boston model, which pits schools against each other to come up with the best drug prevention program. We requested that part of the scoring be based on having a good dropout prevention program. The winning school gets 53 tickets to a Pistons basketball game and other recognition.

We also have supply-side programs. One local version is "Operation Rip-Ride." Under Federal law, local police departments can confiscate not only the property of the drug pusher but also the car used by the drug purchaser. That is a very important tactic. In Detroit, because prisons are full, 90 percent of the people convicted of drug sales are put on probation or are given suspended sentences. However, if we can take their cars away, we can help push the sale of drugs underground. Because it is with new users that the epidemic spreads, anything that inhibits new users from making drug purchases will help control the epidemic.

Confiscations of dealers' property is a high-priority matter locally. So is prison development. I say that without apology. It is a part of a comprehensive community prevention program. We cannot seriously say that we have clear and consistent norms about drug use and drug trafficking if we arrest people for selling drugs to a cop, convict them, and then give them a slap on the wrist and send them away. What does that say about our community norms? In Detroit the shortage of correctional facilities at the juvenile level is so serious that juveniles who sell drugs to police officers and get arrested are given tickets and sent home. Obviously, more correctional facilities must become a part of our program, too.

I have tried to sketch what it means to have a comprehensive program. The model that has been used in Detroit is described in detail in our prevention plan. I think it makes ecological sense.

Dr. Murray: The Kenilworth/Parkside Resident Management Corporation (KPRMC) is a unique and highly acclaimed community-based organization. As a result of tenant ownership, which dates back to the 1970s, KPRMC was established as a pilot effort in 1982 for tenant ownership and management. Today it represents approximately 3,000 low-income, predominantly Black public housing residents of the Kenilworth/Parkside developments. KPRMC has been lauded nationwide for its creative and wide-ranging roles, and it has served as a role model to communities throughout the Nation, to the benefit of the residents of Kenilworth/Parkside and the surrounding community.

KPRMC serves as a management agent for 464 units. In an independent analysis conducted by Coopers and Lybrand, it was stated that KPRMC has achieved a commendable success rate in key management indicators. This fact is particularly noteworthy when it is compared with a conventional public housing development and with the overall citywide inventory of public housing.

The Department of Housing and Urban Development (HUD) recently awarded $21 million in modernization funds to this development. KPRMC is also the Nation's first resident management corporation to be involved as a joint venture partner in its own rehabilitation project. Furthermore, approximately $1.8 million in public housing funds will be used for KPRMC to develop 20 turnkey home-ownership public housing units.

KPRMC has played a key role in creating an environment of pride and self-sufficiency within the community. This positive environment has resulted in a reduced dependence on public assistance and a reduction in crime, as well as in substantial participation by residents in maintaining the community and contributing their time, on a paid or volunteer basis, to its well-being.

KPRMC is well known for its efforts in promoting opportunities for higher education for its youth through its program called "College Here We Come." Equally important, it emphasizes success in employment and in training.

KPRMC is also responsible for directly establishing, or for obtaining outside funding for, services to be provided onsite. These services include a day care center, a complete health clinic, and nutrition and exercise programs. Residents are encouraged to create other services for themselves, such as a convenience cooperative food store, a barber and beauty shop, and so on.

KPRMC generates considerable volunteer participation in its efforts, particularly in the day care center and the "College Here We Come" program. It consumes all our time and the time of the residents.

Like other local neighborhoods, Kenilworth/Parkside became affected by the ravages of AOD use. Beginning in 1981 the community went from a quiet residential community on the borders of the District of Columbia to a well-known, open-air drug market. It was not uncommon to see more than a hundred illegal drug users and sellers plying their wares without fear of sporadic local law enforcement. Many of the people involved were not residents of the neighborhood. But eventually, the rate of addiction and sales by residents grew alarmingly. Other residents became fearful to walk in the streets. They also feared the crowds and the violence that became a part of the market's notoriety.

Unable to tolerate this situation any longer, the Kenilworth/Parkside Resident Council held a series of emergency meetings. Every family was informed of the crisis and was asked to participate in an all-out effort to free the

community of open-air drug sales. A plan of action was developed to rid the streets of this growing menace.

The plan focused on mobilizing entire families to participate in daily marches. Placards were designed and carried to draw public and media attention to the problem. A task force was organized to meet with local metropolitan police and other law enforcement agencies, who had in the past made only sporadic attempts to help. The residents cooperated with the police in identifying housing units involved in the sale of illegal drugs, and they consistently called the police when observing drug sales on the properties.

The metropolitan police responded by making KPRMC its first police substation. They installed a trailer on the property, which enabled police officers to operate 24 hours a day. After hundreds of arrests, the confiscation of over $1 million in illegal drugs, and full mobilization of the community, the streets were cleared.

But KPRMC recognized that this law enforcement response was only a partial answer to the growing social problem of AOD abuse. There was also a dire need for short- and long-term solutions if current community improvement efforts were to be successful.

To cope with the problem, the residents expressed a need for a community-based prevention and treatment program. KPRMC brought together a number of people with experience in the field of drug prevention to develop a concept of family-focused prevention. Education and treatment programs also were urgently needed, which could deal directly and aggressively with AOD problems. These programs formed the basis of the existing Kenilworth/Parkside Substance Abuse Prevention Project.

This project is funded by the DC Department of Housing and Community Development and by ADASA. Initiated in March 1987, it offers a wide range of services for area residents, ages preschool to adult, and it provides a series of activities that seek to prevent all forms of AOD problems through the creative use of educational and informational strategies.

I now want to outline how we arrived at three of the activities we have worked on aggressively since the project's inception.

First, we designed a work plan so we could meet the goals we had in our proposal. We knew we wanted to keep primary prevention as our focus, although at times we had to do short-term intervention or some therapy and aftercare. But we look forward to being good prevention providers, giving out good information, teaching people how to make good decisions, and promoting increased self-esteem. Our basic goal at KPRMC is the achievement of self-

reliance and independence, through both building self-esteem and looking at our values and belief systems as a family group and a community.

Next, we developed a needs assessment. (Part of what we do at KPRMC is to provide jobs for our residents. Thus, our seven staff members who live in the housing development were trained to survey the community using the assessment tool.) Its results enabled us to better plan and promote our prevention activities.

Actually, there were two assessments: one was directed toward youth; the other, toward adults. Of the youth, 116 young people were interviewed, most of whom fell between the ages of 17 and 21. Sixty percent of them were male, and the majority, 96 of them, were completing school. The next highest percentage was in the 7th and 8th grades.

The activity that the kids most frequently indicated they liked was sports. They used our recreation center as the place for these activities for the most part. Over a third of the respondents indicated they liked the activities that had been sponsored, and also the people, especially the attitudes of the people who worked with them.

Drug use, crime, and alcoholism emerged as the problems most frequently named in their community. Drug use was the problem most frequently indicated as affecting the youth. However, a majority of the youth responded that they had not used alcohol in the past month, although a little over half of them indicated that they knew of other youth who drank or used drugs. Peer pressure and problems in general were the reasons most frequently cited for why teenagers used drugs.

The developers, some of our other staff members, and I, realizing that we were using very young interviewees—young in age and experience—felt that perhaps some of the teenagers did not want to divulge all the activities or behaviors in which they were involved.

Among the 132 adult respondents, the most frequently cited problems affecting youth in the Kenilworth/Parkside community were (1) AOD problems, (2) teenage pregnancy, (3) family disorganization, and (4) crime. Eighty-six percent of the respondents considered drug use to be the most important problem affecting the community's youth; the other problems considered most important were family disorganization, inadequate education, teen pregnancy, and alcoholism.

Peer pressure and other environmental influences were most frequently cited by adults as the reasons why they felt young people used drugs; family and school problems also were listed.

As we were going to the individual housing units and asking the questions, and before we were actually able to have the data analyzed, we basically knew the activities and the problems to which our neighbors felt that we needed to respond.

Because summer was approaching and one of the activities we had designed in our proposal was a homework center, we came up with the idea of having what we called a Substance Abuse Summer Academy. We structured the academy around four areas: information and education about AOD use, cultural information to give us an idea about socialization and value systems, academic reinforcement to keep up the young people's academic skills, and therapeutic recreation to aid them in exploring our world.

This project gave 170 young people between the ages of 2 and 22 the opportunity to work with us for 6 weeks. The youth who were 14 and older and involved in the Mayor's summer youth program received payment for the work they did. They developed skills in three workshop areas: printing, filmmaking, and silkscreening. They also spent an hour and a half of every day in group counseling, where they received information on AOD use.

The silkscreening summer workshop was the result of one group's thinking. They did their own designs. Many youths who had not previously been involved with the project came in as a result of this workshop.

We noticed that we had a lot of young parents in our older group. As we approached the end of our funding cycle, which was in September 1987, we decided that we wanted to work toward a prevention program for this group of 18- to 30-year-olds. That program is now in the works.

The second program we piloted is a volunteers program called Block and Floor Captains. The participants are adults who have volunteered to take information to the housing units in their areas. Ten women participated in a 10-week training program. During this period we applied for an ACTION grant, using our pilot as the basis for our proposal. We were funded by ACTION in September 1987 so we could continue the program.

These 10 women are the core trainers for approximately 60 other community-based people, who represent our crisis prevention strategists. They hold meetings in their kitchens and in their living rooms, and they assist us in referrals and dissemination of resources and information. They provide community order and organization.

They are also the people in the community who are trained to take over when the professionals who are involved in the project are no longer there. It is important for us, as the professionals are phased out, to be assured that the projects are intact so that the programs can continue if the money dries up or if

something else happens. Trained to replace the professionals, the residents feel responsible and capable to carry on because they have the information and can disseminate it.

The third activity I want to highlight is called Inner and Outer Images. Our young community workers wanted to focus on activities for youth after school and on the weekends. Basically they said, "Let's ask the young people what they want to do." The young people wanted a Teen Rap Center.

One of the things that KPRMC's resident council wanted to do was to ensure that young people were trained in leadership skills. As a result, we asked the young people to think about forming a youth council, which they did. Their selected officers were then trained in leadership skills and in AOD use prevention education information.

We got involved in Inner and Outer Images because we wanted them to use the information practically and we wanted to help the youth build self-esteem. We said to our young people, "Well, let's take a look at this image building." And then, from a practical point of view, "Let's bring in some people to talk about color, design, and how to make your garments. And along with that, let's talk about making this a business." They said to us, "We need to make money. We don't want to be involved in the selling of drugs. But we need some money."

Together we worked on the issue of how to help them make money and on some practical skills that had to go along with that issue. Involvement in making money meant learning how to do banking, investing, marketing, selling, and designing a business, the product, and logistics. And we used resources from the wider community to assist in teaching practical matters such as how to select, make, advertise, and sell a product. Profits were reinvested into the company to make more money.

This process is what capitalism is all about. Someone said to me, "Well, that's the junior achievement model." I answered, "Well, fine, because we want to bring that model right to our housing development." The young people come, and they enjoy it, and they look forward to it. And so do we, because we expect them not only to become young entrepreneurs, but also to understand the whole business world, both from their current perspective and for their future.

It is exciting. We look at our work as investing them with power, making them examine their value system, and pushing them toward excellence and toward caring for themselves and others, particularly the elderly.

Most recently, we looked at their outer image again—this time in terms of manicures, hair styles, and shopping. We had a professional designer work with them in these areas.

For the young people involved in the youth leadership and investment groups, we sponsored a trip to Wall Street for a weekend as a treat for them. And included was an activity based on the therapeutic recreation model they were using, which would culminate in a ski trip.

One other thing we have is a homework center. It is important that the young people concentrate on their studies. If they do not have homework assignments, two teachers from the DC public schools provide activities for them as educational reinforcement.

Our homework centers are extremely popular, particularly for the young children. The teenagers from ages 13 to 15 are less likely to come in to sit down to do their homework. But as long as we can combine studying with something exciting like moneymaking and other activities, we can be assured that teenagers will be involved.

KPRMC works diligently in the academic community in all levels of schools in our area. We have an offsite group with whom we work in our housing development, too.

We look forward to having a working community that is safe and secure from drug abuse. We want to promote a healthy, growing, loving community, especially for our children. They are our hope for tomorrow. And basically, they are our autographed legacy.

Dr. Thomas: I am vice president of the Human Resources Development Institute (HRDI). I am also on the faculty at Northwestern University Medical School, where I supervise and train the professional staff and the graduate clinical psychology students through Northwestern's chemical dependency program.

In addition, I chair the education committee of the Illinois Certification Board. The board provides accreditation standards for college and university preparation training programs for counseling and prevention training in AOD abuse. So we do the accreditation of colleges and universities.

Recently, I was reelected as the chair of the AIDS Foundation of Chicago Service Providers Council. The council is made up of 33 organizations that provide AIDS-related treatment, education, and supportive services in the Chicago community. I was also asked by the Chicago Department of Health to serve as a cochair for their internal AIDS Advisory Panel.

In Chicago and throughout Illinois and the United States, I have provided consultation and presentations for many prevention projects, conferences, and programs. The one thing that has become apparent is that prevention is not generally targeted toward Blacks.

When we have workshops and forums that address prevention issues, unless they are particularly targeted toward the minority community, usually few or no minorities are involved. I attended a State conference implemented in three different sites and targeted for three different populations: inner-city, rural, and small urban. Chicago has the largest number of Blacks in Illinois. Thus, in the Chicago area, one would have expected to see a majority of Black people. But less than 1 percent of Black people were represented at that conference. The message that I get repeatedly is that prevention is not targeted at Blacks.

When we talk about AOD abuse, especially intravenous (IV) drug use, it is important to remember that these drug abusers are the people who are primarily at risk for contracting and spreading AIDS. Although a disproportionate number of IV drug users are Black, again, prevention is not targeted toward Blacks.

Then I am reminded that charity begins at home. We must begin to take responsibility for our own. I mentioned recently to a colleague about how both of us had submitted grants for Federal funding for our prevention programs, and yet neither of us was granted funds. And I told her, "Now I understand why, after listening to your program." It is because her group is doing something, something that is significant for Blacks. Hers is a leadership development program, just as ours is.

Here I want to digress a bit. I get angry when I look at what is happening and I see Black people dying and continuing to die by the millions. Yet they are ignored. They are allowed to drop through the cracks. I see it happening everywhere, and I am overwhelmed. I do not know what to do about it except to keep doing what I can, where I can, with whom I can.

The public housing development in Chicago is the second-largest public housing development in the United States, housing 145,000 people. Of those people, 50 percent are Black and minority, and 53 percent are under the age of 21. I mention public housing because that is where we are going to find most Black people in one targeted area. Thus, that is where the biggest impact can be made. Just because people are poor or Black does not mean they do not have the capacity to learn or to achieve. In fact, in public housing one can find some truly bright, creative minds.

It has been said that we should listen to the kids, to what they want to do. We should not ignore what their wishes are. They are telling us how they can learn best. That is why, in 1982 HRDI developed a leadership training program.

Just to present a little of its background, I have been asked for the past 3 to 4 years to speak all over this country and to present our model. Yet when we ask for funding from the Government, we are told it is too ambitious: "If you could make it work, it could be highly replicable. But it's too ambitious."

Why? Because it involves the public housing community. Yet it is a model that has worked successfully for the past 5 to 6 years on a budget ranging from $32,000 to $40,000 a year.

And when that is added up over 6 years, the amount of money that we have received for prevention within public housing for those 7 years combined, divided among the number of people under age 21 living in public housing, amounts to *less* than a penny per person.

Public housing is the seedbed for everything bad that can be found in this Nation: crime, child sexual abuse, gang involvement, AOD abuse—generation after generation after generation.

And I cannot and will not believe it is because we have a people who are genetically inferior. Instead, we have a system that has allowed a whole race of people to fall through the cracks and to be ignored.

Some people have mentioned the role of the churches. The church is the foundation of the Black community, the one thing that has been able to bring us through slavery to where we are today. Despite the fact that our forefathers were dragged to this Nation in chains, stripped of language and culture and family, we have been able to make our families work and we have been able to hold those families together.

And when it comes to AOD, we are going to have to recognize the external forces that impinge on Black people, on Black kids, on a Black family, and begin to fight those forces.

My conclusion is that we cannot depend on Government. We cannot depend on public funds. Charity begins at home, so we are going to have to begin at home, starting with whatever it is that we have and doing whatever it is that we need to do.

I get quite emotional about this because when I look at AIDS, at drugs, at alcoholism, and at crime, I realize that we are operating in a system in which the forces are invisible. So we begin to think that, somehow, we are not doing something we ought to be doing, or that we deserve whatever it is that is happening.

And that is not it at all. This society is capitalistic, and we are in a competitive market. And when we look at what is happening on Wall Street with the market plummeting, we see people getting wiped out and $500 million being lost in one day. Our Black kids cannot even imagine having $500,000 or $500 at one time, much less *losing* $500 million in one day.

These are competitive times. In a capitalistic society, that means that those who are most fit will survive, rise to the top, and be successful. It is very competitive.

So it is not hard to understand why the public school systems in Detroit, in Chicago, and all across this Nation are in trouble. I remember back in California in 1983, when there was a referendum—I think it was called the Thirteenth Referendum—in which people who had their children in private schools did not want to pay taxes that went to public schools. So as far back as 1983, there were warning signs.

The public school system is allowed to fail. It is allowed to produce products who are not able to become successful within this system. If we have kids who are dropping out before they get to high school, then we know there is a whole group of kids who will not be employable, who will not be able to compete for the dwindling jobs and the dwindling resources.

But we are pouring thousands and thousands of dollars into the criminal justice system. Why? Because we are building walls to contain people who are falling through the cracks.

As I said earlier, ours is a leadership development training program. What we do is to teach leadership development skills. And once we can teach leadership development, we have a foundation on which we can place any content we want, be it AOD use and abuse prevention, AIDS prevention, crime prevention, teenage pregnancy prevention, suicide prevention, or whatever. It is a model that works.

I am happy that other public housing developments around this country are doing similar things—that is, teaching our kids not just how to say no to drugs but also how to be competitive in a competitive market in a capitalistic society. The problem is that the kids do not have the skills. They are not taught or given the skills. And, in fact, in many instances, the skills are blocked.

I have a brother who is now 22 years old. When he was in high school, I was stunned when he told me that going to college was a waste of time. And I said, "But, Dwayne, you can do anything that you want to do." And he replied, "No, you can't. White people won't let you."

Now I have a Ph.D. I have another brother who has an M.A. People in our family are doctors and lawyers and come from all walks of life. So where did this kid get this idea from?

And I had to step back and see that, somehow through his experiences that I cannot see, he is getting this message loud and clear. And if he is getting this message when he comes from a high-achieving, success-oriented, extended

family, what must other kids be getting who do not have those types of role models close by?

I heard someone say recently that the kids are smart because they understand those messages early in life. And what we have to do is take the responsibility for countering the messages that they are getting and for sending different messages.

We can no longer depend on the public school system to provide what it is that we need if we are going to be able to exist in the year 2000. And I hear a lot of lectures and public speaking engagements about "Will Blacks Exist in the Year 2000?" At first I said, "Well, you know, that's not so far away." But I have to ask, "Is that a legitimate question?" And I think it is, based on what we are seeing and on what is being allowed to happen.

And when I look at the prevention programs that were funded, at where the prevention models are allowed to flourish, and at where the prevention programs take hold and expand, what I realize is that prevention is not for Blacks unless we make it for ourselves.

This point brings me back to our program again. I want to talk briefly about prevention in terms of building skills within the individual, and about what drugs do and do not do based on that individual's own internal strengths and abilities.

The learning model—that is, the model we use in developing the program and the program components—is based on an anthropological model, which is used for teaching adults. Even though there is supposed to be a difference between how we teach adults and how we teach children, the model that is usually used to teach anyone is a pedagogical one. An example might be a lecture in which there is one person up front or on stage talking and others sitting in the audience as listeners or learners. And that is how we teach children. It is usually a one-way street. In our anthropological model, however, we believe that learning is experience and experience is learning.

The learning model has four basic principles. First is self-concept. According to this principle, the learner is a teacher and the teacher is a learner, so there is a shared learning experience—not just one person providing knowledge, and one or more persons simply receiving it. So when we deal with kids in terms of leadership development, we give them the material, and they teach each other. They also teach us.

The second principle is independence. And that means they have the ability to choose. Through our cultural and fine arts workshops, the kids decide what their own interest is—drama, modeling, art, or what-have-you. And once they have decided the kind of cultural and fine arts workshop in which they want to

be involved, that is how they learn the material we give them. Thus, if they decide they want to be in drama, they develop plays around different aspects of drug use. If they want to be involved in journalism, they will write articles.

The third concept is experience. The belief is that everyone—from the day he or she is born—has experiences, so we believe that the kids who come to us have already had a variety of experiences. And those experiences are valuable in terms of their own learning. That is where history and culture play a role.

Finally, and probably the most important, is immediacy. This means we do not learn information today for some future use; if we learn information today, we use it today.

So we teach leadership skills and leadership development. And if the kids who are taught those skills are taught about AOD use, or about how such use affects the body, they are immediately asked to take that information and teach it to someone else through one of the cultural or fine arts workshops, using their own creative way of teaching. We may give kids information and tell them to go away for 25 minutes to read the material, do a play, or develop a 60-second commercial based on that information, and then come back in 25 minutes and teach it to the rest of the audience. Then, a year later, we can ask them information about what they learned, and they can pull it up just like that and not even realize that they had it.

Why? Because they learned it when they were doing something they wanted to do. They may have been focused on developing a play but what they were doing was learning and encoding the information.

Prevention Models for Black Youth at High Risk: Health Care and Civic Organizations

Participants: Ms. Clemmie Saxton, *Moderator;* Ms. Mitzi Rosemin-Pierre, *Co-moderator;* Dr. Wilbur Atwell, Dr. Flavia Walton, Dr. Bettina Scott, and Mrs. Marsha Zibalese-Crawford, *Panelists;* Dr. Kwamena Ocran, *Recorder.*

Dr. Scott: By way of introduction, one of the things we are hoping to do at the National Clearinghouse for Alcohol and Drug Information—the new combined Clearinghouse—is to provide national organizations with the resources of the Clearinghouse to help them carry out meaningful programs for their internal organizations and their communities.

We have the largest library and database on alcohol and other drug (AOD) use information in the country, containing over 65,000 items. We provide a reading room at our site in Rockville, and the database is available for various research projects.

In 1987 OSAP funded 131 grant programs, in the hopes of obtaining additional information about strategies that work both in the Black community, certainly, and in other communities as far as high-risk youth are concerned. To this end, we added to our database not only basic research information but also programmatic information to give us some program descriptions and some evaluation information on the programs and strategies that work.

In addition, we have also developed a network of national organizations and programs that we call on to find out what is happening in local communities. The mission of OSAP is to provide local communities and grassroots organizations with the kind of technical assistance they need to implement programs within their own communities.

We have found that people in the communities know more than the "experts" about the nature of the problems within their communities and are better able to come up with a number of creative strategies to address those problems. We have a large technical assistance contract, and that assistance will be provided to those local programs. For instance, someone may have a program in which the activities are pretty good but the evaluation is weak. We are finding that several of the 131 funded programs need help with their evaluations. The Technical Assistance Contract will be able to provide that help so that, at the end of the project funding period, we will actually be able to measure what has happened and what impact it has had, as well as what processes have been going on, so that we can draw some conclusions about what might work within various communities under certain conditions.

I would also like to discuss briefly the program that the Zeta Phi Beta Sorority is sponsoring, called Project Zeta. This program is the Zeta's national AOD abuse prevention project, which began in Baltimore. I was instrumental in getting that program started there and also in getting it adopted nationally. We really backed into the AOD prevention programming. Some members within the local chapter wanted to change the focus of our community service projects. At that time, we were running three separate such projects.

One was called the "Stork's Nest." It was a program designed to help low-income mothers receive prenatal care as early as possible. One way of influencing them was to provide layettes and maternity clothes for them at a very reasonable cost, and sometimes for free. So we ran a shop, generally at a community center. We were particularly interested in conducting outreach to young women in these communities to encourage them to get prenatal care.

The second service project we were sponsoring was a tutorial project at a recreation center. On Saturday mornings chapter members who were teachers would provide reading and math assistance to young people who used the recreation center.

The third service project was a voter registration project.

But we felt that those programs had been going on for 20 or 30 years. The same people were involved in them; there was no new focus. So about five Zeta members decided to look at some of the other needs in the community, and they came up with the idea that what was really lacking was some kind of AOD use prevention for our local community. Then, so we could get it on the chapter's program and agenda, the five sponsored workshops for the members during their regular meeting time.

Imagine telling a number of people who felt that community service should be restricted to tutoring youngsters on all kinds of "safe" issues that it is time to focus on AOD. As might be expected, their first reaction was "We don't have any experience going out here treating anybody who's on drugs." To which we replied, "We're not asking you to treat anybody. All we're asking you to do yourself is to raise your awareness about the issue."

So we spent about 3 years in workshops, off and on, just to raise the awareness of the members we wanted to involve in the project. We sent them off to conferences so they could come back and report to the total membership on what this whole prevention thing was about.

After 3 years, the Mayor's office asked us to adopt a school as a part of its Adopt-a-School Program. We decided that one of the things we could do for a school was to provide AOD use prevention education. We had five members in the group who had some experience. We decided they could use this expertise

in providing some workshops and training sessions for teachers, parents, and students within the school. So we adopted a school, and we had coffee hours for the teachers. During these hours we provided some AOD use prevention information. We also were able to provide some materials from the Clearinghouse to help raise the awareness of the teachers.

Now this was a middle school. In some of the middle schools, youngsters did not have a health curriculum so they were not always being taught AOD use information. This program, then, was an addition to the curriculum, and the principal was very supportive of the program.

After 1 year of training teachers and involving the youngsters in Friday afternoon rap sessions and AOD information sessions, along with films and other activities, we had a big culminating activity called "Alcohol and Drug Awareness Week." The youngsters participated in poster and essay contests. It was not anything earthshaking or new but it was different for that particular school because they had never done anything on AOD use prevention before, and certainly they had not had the opportunity to invite outsiders to come into the school to do anything.

Along with the AOD use prevention information and training sessions, members who were retired teachers also provided services to the teachers within the schools. They served as additional teacher aides. They helped teachers do bulletin boards around AOD awareness, and they also provided additional help by supporting different kinds of social activities for the youngsters connected with the school program.

The principal thought it was such a good idea that at the end of the year, she reported it at a principals' meeting. Other principals then wanted us to come into their schools and do something on the order of what we had done at that particular school.

So in the second year we again adopted the first school, along with three additional schools, and again trained teachers. Someone came up with the idea that one way of organizing or rallying the youngsters around a theme might be to organize Just Say No clubs within the schools. Then we could connect them with the national network of Just Say No clubs, and we would have a body of material that we could provide for the schools. So in the second year, we began to establish these clubs.

To be sure, Just Say No clubs are not a bunch of youngsters running around and saying, "Just say no." But they have this motto as a theme, a way of organizing the youngsters, and then the youngsters plan for themselves the activities in which they would like to participate.

Many youngsters in those schools decided on good projects that they wanted the clubs to do. One school was located about a block from a nursing home, so twice a month the club members would walk down the street to the nursing home and just visit with its residents. One thing that seems to be coming out in some research is that in many prevention programs, getting youngsters involved with helping somebody else in itself helps those particular youngsters with their own problems. They are not interested in becoming involved with AOD if they really think they are needed by somebody else. This principle applies to peer programs as well. If a youngster thinks that he or she can help another youngster stay off or get off drugs, then that conviction alone helps the particular youngster who is trying to do the helping.

These groups are all in inner-city schools in Baltimore, and one group decided that its school needed a cleanup program. So they put forth a big campaign within all the classrooms to have youngsters clean up and plant flowers around the school. Anybody caught walking over any trash in the courtyard or in the school would be cited. The youngsters made up all these rules themselves, and hey implemented them with the support of the adviser for the Just Say No club. So it was more than just youngsters running around saying, "Just say no." They were actually making plans to improve their own environment.

At the end of the second year, the principals of those four schools were quite laudatory about the program when reporting on it to the school board, so we were asked how many more schools we could adopt. At that point, because we had been supporting these efforts out of our community service funds for the chapter, we decided we would apply for a grant from the State of Maryland. We were funded, but it was not a huge amount of money. They funded us something like $8,000 or $10,000. But we knew it would certainly help.

So we issued a request to principals: If you think this program is something that would work in your school and you could identify someone within your school who would serve as the club's adviser, fill out this form and return it to us. We were hoping at least 10 people would participate.

In fact, we got 27 principals who said they wanted it in their schools and had an adviser who would meet with the group once a week. We provided training for those 27 teachers in conjunction with the national network of Just Say No club advisers. We also paid for someone to substitute for those teachers while they were taking the 1- or 2-day training.

Once they were trained, they set up the plans for each of those schools. Each club is different. Their only similarity is that they are all sponsored by the Zeta Phi Beta Sorority and call themselves Just Say No clubs. But the clubs themselves decide what activities they want and what activities would best suit the people within the school.

There are some things we tried to do to make all the clubs connected or unified. One thing was to provide a T-shirt for each member. On the front it says, "Be Smart. Don't Start. Just Say No to Drugs." On the back it says, "Sponsored by Alpha Zeta Chapter, Zeta Phi Beta Sorority." A second thing was to have them develop a design for a pin. We ran a little contest for the pin design, and the school that won received some additional money as a prize. The pin says something about "Just Say No," and it is in blue and white, the Zeta colors.

We also were providing volunteers to the schools as speakers. We found businesses in a couple of the communities that would support some of the school's activities: T-shirts, buttons, or materials they wanted for projects. Or they supported the weekly meetings by providing cookies and punch and things like that—just incentives to get the kids there. We believed that once the kids were there and had an opportunity to plan their own program, they would come back. We needed a hook to get them there, but the program itself was of such interest, the youngsters remained.

We also connected them with the national Just Say No network by purchasing handbooks and materials from the network for each of the programs, along with the national newsletter.

We then thought of another way of connecting all the groups together within those 27 schools. We sponsored an essay contest, a poster contest, and a banner contest. Each school had a winner, and those winners would come together at the end of the year and we would award them money.

We sponsored Drug Awareness Days within each of the schools, and at the end of the year, we sponsored what is called a Prevention Fun Fair. Each youngster who was involved in the club brought any projects he or she had done, and we decorated the hall. We had it at a high school and we had use of the gym, the auditorium, and a large auditorium hall.

The students put their banners and their posters up, and then we offered all kinds of fun activities at which they could win prizes. We had Just Say No posters from the Clearinghouse, the Cosby Kids poster, Cosby Kids comic books, and a number of other prevention materials that we gave to the youngsters. We also had a Stevie Wonder poster. The posters were probably the most popular items with the kids.

We had a ring toss game. The object was to get Just Say No on the ring toss, and a poster of the Cosby Kids saying, "Just Say No," was the prize. We had videos as prizes. We had a clown who sat on a big barrel, and the kids would have to ring a bell with a ball marked Just Say No; and then the clown, of course, would fall down into the water. The kids could win a prize doing that. We provided almost every carnival game imaginable that day for the youngsters, all connected in some way with the Just Say No theme.

We also had things like postermaking and arts and crafts for the kids to exhibit their skills and give them something they could use the next year. And we had face painting, which was really popular; some of the kids had Just Say No painted on their faces.

Schools won all kinds of money for their posters or their essays, and each school also was given a grant of, I think, $75 for having participated. That money could be used to start up activities for the next year.

That is just a thumbnail sketch of what one chapter did. But because we were so successful in that one chapter, we took the idea to our national body and said, "This drug use prevention program is a good idea. It is something that all chapters can do within their communities."

So the Zetas decided to adopt it as a national program strategy. All the chapters throughout the country now have Just Say No clubs within schools. Community- and church-based programs are being developed within neighborhoods to promote the involvement of families in education and prevention activities. The sorority promotes the involvement of college students in AOD prevention programs that educate them about AOD abuse and, through its undergraduate chapters, supports drug-free social activities on campus.

In our health clinics and in our Stork's Nest programs, chapters are incorporating not only drug use and abuse education but also AIDS information for their programs on prenatal care to low-income women.

In some communities Zetas are assisting in the development of prevention projects in criminal justice settings and family support groups for people in prison. All of these incorporate AOD use and abuse education and information on safe sex.

Ms. Zibalese-Crawford: I have been involved with the Washington Area Council on Alcohol and Drug Abuse (WACADA) High-Risk Youth Prevention Program from the very beginning when the request for proposals came out from the Office for Substance Abuse Prevention (OSAP). At that time, I had the opportunity to consult with WACADA and five other organizations and plan what we would like to suggest to OSAP for a specific demonstration grant.

We are 1 of 131 grants that were funded, and we are going to do a comprehensive AOD use prevention treatment and rehabilitation program for high-risk youth. The groups that are involved are the WACADA, (RAP), Sasha Bruce Youth Works, Andromeda, and the Latin American Youth Center.

The umbrella organization for this consortium (and that is what we are calling it) is the Community Foundation of Washington, DC. It will oversee all the financial management for this particular grant.

We have not yet met as a unit, however, to flesh out all the ideas that were put into the proposal. But I can describe what we have come up with, who the high-risk youth will be, and what our specific goals will be for this particular grant.

The youth whom we will serve are current AOD users. They are economically disadvantaged. And each has at least one other risk factor: he or she is the child of an alcohol or other drug abuser, the victim of abuse, a school dropout, someone who has become pregnant, someone who has committed a violent or delinquent act, someone who has a mental health problem or who has attempted suicide, or someone disabled by injuries. Those youngsters are the only ones who will be served through this particular grant.

When the consortium participants began to propose this specific project, the consortium as a unit felt it would be appropriate for them to try to serve all the young people who qualified as high-risk youth. So, youth who used AOD on a social basis will not be targeted unless they fit into these other categories because it would be impossible for us to meet the needs of every youngster in the District of Columbia.

What the consortium wants to try do is incorporate all the organizations within the District to work together as a unit to meet the needs of high-risk youth. The program goals will incorporate services such as counseling; education; training; development of a referral agency and agency networks, creation of a diagnostic assessment tool, and referral to a mechanism; institution of a comprehensive case management system; provision of intervention and treatment services for youth AOD users, for parents of the youth who have significant AOD use problems, and for the children of alcohol and other drug abusers; and establishment of a community-based resource center.

The resource center will actually operate out of WACADA. It will be the beginning place through which everything will be channeled. We will then begin to "network" into the community with RAP, Sasha Bruce Youth Works, and all the other organizations that will become part of the council.

The group envisages this program as a successful outreach program to the community because, as they see it, people do not now work as a unit within the District. Everyone is out there doing his or her own thing and people do not seem to come together to work out ideas or to talk about how to refer a specific child to someone else to get treatment.

For example, in the Latino community, they are finding that the Latin American Youth Center will not refer people to the mental health center in that community because it does not like the work that the mental health center does. This effort, then, will enable the Latin American Youth Center to learn about and refer people to other treatment centers throughout the community.

The consortium also offers services that will include planning and linking a broader array of youth service providers, who will all become part of this particular grant.

The Resource and Training Center will make training available for all community organizations throughout the District. We will be able to do training in relation to AOD use education for volunteers and for individuals who want to go through and obtain their certification as counselors. All this will be made available through this particular training grant.

In addition, the group feels that a key element is the implementation of a case management treatment and referral system, which will enable the city to overcome the fragmented delivery of services. The group expects the result to be a comprehensive continuum of care for high-risk youth who are placed into the case management system. There will then be a definite followthrough. The child will be referred and will go into treatment. There will be a followthrough system developed so that the child does not leave the specific treatment center to just go off into the community. Certain people will follow through on the particular individual.

The staff of public and private agencies and schools will receive expert training and technical assistance on how to recognize the signs of AOD use among youth, how to recognize other risk factors for teenagers, how to obtain a comprehensive assessment for youth at risk, and how to obtain a single source for referrals and information on the latest prevention and intervention techniques available, as well as for speakers and volunteer services.

One of the key elements is evaluation. We intend to collect and analyze data on the target population. This strategy is part of what we need to do to receive further funding on the grant; also, this activity will enable the District to see what is going on within these high-risk groups. It is not just a program being implemented with no statistics being kept. The information will contain characteristics on the high-risk youth population, which we can use for further studies within the District.

The project will create a council of service providers that will bring together all community organizations dealing with AOD-using youth. So we will be asking organizations to become part of a council and to help us meet the needs of the entire community. We hope that organizations will join us in this particular grant.

Another key element is the creation of a youth advisory council to advise the consortium organizations, so it will not just be adults thinking about what they need to be doing in the community. We are also going to ask the youth to become a part of this particular project. The key purpose of these councils are to provide valuable insights regarding the need to coordinate services, to identify the

potential to share services, and to identify gaps in our services. So if we are not meeting the needs, we will find out why and then change what we are doing.

Another key purpose, and what we see as the focal point of the service delivery for high-risk youth in the consortium, will be to serve as an advocate for change. Advocacy for change, especially as it relates to how public and private services are organized to serve high-risk youth, is a definite focus.

The reason why all these organizations decided to band together is that they wanted to see a multiethnic group working to meet the needs of the community. This development occurs because the District does not just meet the needs of one specific community, it meets the needs of many types of communities. The need is for people of various cultures to come together into one specific unit, and that is how the consortium sees what they will do in the District to be multiethnic. Two organizations have suggested how we could accomplish this task. They decided to bring in other groups, such as the District's Jewish community. They have asked Northwest DC in, and they have asked RAP and Sasha Bruce and many other organizations to be a part of this effort.

I cannot describe much else because we have not actually sat down and actually planned what the case management system will be, or decided who will sit on the advisory council, or of any of those details. So, in essence, these are just the bare facts about this specific proposal.

APPENDIX A

Forum Background

Program

1987 Human Ecology Forum

"The Ecology of Alcohol and Other Drug Use: Helping Black High-Risk Youth"

The Department of Human Development and all divisions of the School of Human Ecology in conjunction with the District of Columbia Department of Human Services, Commission on Public Health, Alcohol and Drug Abuse Services Administration, the District of Columbia Public Schools, and the Institute for Substance Abuse and Addiction, Howard University, proudly host the 1987 Human Ecology Forum, "The Ecology of Alcohol and Other Drug Use: Toward Primary Prevention Among High-Risk Youth."

Alcohol and other drug (AOD) use among youth continues to pose serious problems on every level of modern society, and dangerously at risk in the District are our Black youth. While many theories have addressed factors related to AOD use, our purpose is to focus on the interaction of factors associated with AOD use among Black high-risk youth and work toward formulation of expanded and refined prevention strategies based on findings from state-of-the-art models and strategies. Participants will interact and exchange knowledge with researchers, practitioners, and policymakers in an effort to propose an interactive, ecological prevention model and/or strategies for Black high-risk youth.

The forum consists of a series of plenary and panel discussion sessions. Each session will provide participant reaction and discussion time. Topic highlights include the incidence, prevalence, and trends of AOD use; factors related to possible causes and consequences of AOD use; and innovations in the prevention and treatment of AOD use.

The School of Human Ecology

Human Ecology is the study of human beings as biological, psychological, and social entities in order to understand processes that affect growth and development throughout the lifespan. The mission of the School of Human Ecology is to prepare students for advanced study and professional careers with the goal

of improving the quality of life particularly for economically disadvantaged members of society. We seek to optimize the achievement of human potential and the development of effective strategies for primary prevention of human problems. The Human Ecology Forum is one mechanism for generating strategies to address these issues.

The School of Human Ecology is 1 of 17 Schools and Colleges at Howard University. Departments and programs in the School of Human Ecology are the Department of Consumer Education and Resource Management, Department of Human Nutrition and Food, Department of Macroenvironmental and Population Studies, Department of Microenvironmental Studies and Design, Department of Human Development, and the Program in International Studies.

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Letter to participants from the Dean of Howard University's School of Human Ecology

Dear Conference Participants:

The Human Ecology Forum was conceived as an opportunity to bring together academicians, practitioners, experts from the public and private sectors, students, and concerned community leaders to focus on a quality-of-life issue of crucial significance. This year's forum focusing on the ecology of alcohol and other drug use (AOD) among Black high-risk youth meets that criterion and comes as well at a critical juncture in the life of both our Nation and the Washington, DC, metropolitan area. Especially affected by the current epidemic spread of AOD use are the youth of our communities.

The School of Human Ecology is committed to the view that the solution of complex social problems requires a multidisciplinary response from the whole community. The composition of this year's forum participants reflects that commitment and will, we think, promote the identification of strategies for the primary prevention of AOD use among youth.

I join with our forum cosponsors from the university, the Federal and District of Columbia Governments, and the DC Public Schools in thanking you for your continued commitment to the challenge of preventing AOD use among youth, and I wish you every success in the activities of the forum.

Sincerely yours,

O. Jackson Cole, Ph.D.
Dean

Letter to participants from the Administrator of ADASA, Government of the District of Columbia, Department of Human Services

Dear Conference Participants:

Alcohol and other drug (AOD) use and abuse are damaging the lives of countless victims and their families all across the country, and most especially here in Washington, DC, the Nation's capital. Hardest hit by this deadly scourge are our youth, in whom we place our hopes for the future.

We have come together today to do more than simply decry the alcohol and other drug problems of our children. Indeed, we know that not all youth are equally at risk for alcohol or other drug problems. We are gathered here to find answers that will aid those most endangered, those at high risk, before they are caught in the web of this disease. We charge you, as conference participants, seriously to undertake the task of developing recommendations for action in what our Nation's leaders have called the most important battle fought by America short of war.

The Alcohol and Drug Abuse Services Administration, along with all of DC government, is convinced that working together as a unified community, we can win the battle against AOD problems.

Sincerely,

John A. Jackson, Jr.
Administrator

APPENDIX B

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APPENDIX C

OSAP Fact Sheet

Alcohol and Other Drug Use is a Special Concern for African American Families and Communities

August 1990

Alcohol and other drug use is one of the leading health and social problems in African American communities throughout the United States. Although fewer African American youth use alcohol and other drugs than do other ethnic groups, the prevalence of this problem remains a cause for special concern within African American families and communities.

This fact sheet answers questions about alcohol and other drug use among African Americans in the United States. The information provided is based on current research efforts including surveys on trends, studies of the health and social consequences, and analyses of the effectiveness of recent prevention efforts in the African American community.

The purpose of this publication is to present factual information about alcohol and other drug use in African American communities and to identify organizations and resources that can help communities and families in creating and expanding prevention programs. Parents, educators, social service providers, community organizers, and health care professionals—in short, all people and groups concerned with reducing the use of alcohol and other drugs in African American communities—are encouraged to use this fact sheet as a tool for developing community prevention programs and activities.

Are African American youth more likely than other young people to use alcohol or other drugs?

According to recent surveys, African American youth drink less than White, Hispanic, and Native American youth, and they are more likely to abstain from alcohol (see Table 1). They also have lower levels of drug use (see Table 2). However, the surveys are usually conducted on high school students, which exclude dropouts. It has not been determined whether more African American students than White students drop out of high school, or whether dropouts are more likely to use alcohol and other drugs.

In the 1988 General Household Survey conducted by the National Institute on Drug Abuse (NIDA), statistics showed that in the 12–17 year-old age group, use of alcohol at least once was reported by 36.6 percent of African Americans, compared with 47.1 percent of Hispanics, and 53.7 percent of Whites. For other drug use, the percentages are smaller but follow the same trend. In the 12–17 year-old age group, use of any illicit drug at least once was reported by 18.7 percent of African Americans, compared with 24.3 percent of Hispanics, and 26 percent of Whites.

The comparatively low rate of alcohol and other drug use among African American adolescents has been verified by several recent independent surveys in nearly every region of the United States. In general, surveys of youth have consistently shown that fewer African American adolescents drink at all. Those youth who drink get drunk less often and have lower rates of heavy and problem drinking than Whites who drink. (6,8,15,18,19,20,28,29)

Does alcohol and other drug use begin later among African American youth than among Whites?

Yes. Both the general population and school-based surveys report that use of alcohol begins later among African American youth than among White youth. (5,6)

Is the lower rate of alcohol use found among African American youth also found among adults?

Yes, particularly among African American women, who have a high percentage of abstainers. Almost one-third of all African American women report that they never use alcohol or that they limit use to a few occasions each year. In contrast, a higher percentage of White women drink more often. There are fewer differences in alcohol use between African American and White men. (28) However, health problems related to alcohol use, such as cirrhosis of the liver and certain types of cancer, have been found to be more prevalent among African American men than among White men. (9)

If African American youth have lower than average rates of alcohol use, why does alcohol and other drug use appear to be a major problem in African American communities?

There are four main reasons alcohol and other drug use seem to be particularly problematic in some African American communities.

1. African American youth—and youth of other groups—who use alcohol often try other drugs or develop patterns of heavy drinking. For example, one survey

found that African American female college students are unlikely to drink to intoxication, but an unusually high percentage of those who do also use marijuana (10). Although African Americans are more likely to be abstinent than are other Americans, African American men who drink are more likely than White drinkers to use marijuana, cocaine, or heroin.

2. African Americans who use alcohol and other drugs experience much higher rates of serious health problems—including cirrhosis of the liver and pharyngeal cancer—than do other groups of AOD users (see later discussion).

3. According to some analysts, members of the African American community cannot easily isolate or protect themselves from the indirect effects of alcohol and other drug use. These include family problems, effects on the local economy, and a high crime rate—particularly that of homicide.

4. Some African American alcoholics and drug addicts encounter unique barriers to successful completion of treatment for addiction problems (see later discussion).

Why do African American youth "graduate" from occasional drinking to heavy drinking and use of other drugs?

Teenagers who use alcohol are more likely than those who abstain to increase consumption or to try other drugs. (10) Although many researchers and policymakers believe that African American youth face greater risks than other teenagers, the scientific evidence does not support this view. In the end, scientists may find that the reasons African American teenagers begin using alcohol and other drugs may not be much different from the reasons that teenagers of other ethnic groups do.

For example, the relative availability of illegal drugs in the inner city may play a role in drug use among African American youth. Availability, however, is not the only variable. In one study, researchers found that African American youth living in Harlem, New York, an area where heroin is inexpensive and accessible, are only slightly more likely to use heroin than are youth living farther from the "street" source of the drug (1).

Some social scientists believe that inner-city youth may be attracted to the "outlaw" nature of the drug-users' culture. According to this view, the use of drugs is less important than the adoption of street values in recruiting African American youth into the drug-using lifestyle (23). The search for "sensation" among young people who enjoy taking risks, perhaps as a means of escaping the monotony and hopelessness of poverty, is also cited as a possible source of the attractiveness of drug use to some African American youth (12).

Other possible explanations for the "graduation" phenomenon include the impact of alcohol advertising targeted at African American consumers, the wealth displayed by local drug dealers, and the publicity given to alcohol and other drug use among African American entertainers and sports figures. Such influences may contribute to an environment in which alcohol and other drug use is perceived to be tolerated.

Sometimes family members may play a role in initiation of alcohol or other drug use. Children may imitate the drinking or drug use patterns of a parent, an older brother or sister, or another family member. There is also evidence that a predisposition for the use of alcohol and, possibly, other drugs may be biologically inherited, even when alcohol and other drugs are not used in the household.

What personal health problems related to alcohol or other drug use are widespread among African Americans?

African American men are 10 times more likely than White men to develop esophageal cancer, which is linked to heavy drinking. Nonwhite men are several times more likely than White men to die of cirrhosis of the liver, an alcohol-related disease; Nonwhite women are twice as likely as other women to die of this disease (9). (Often mortality rates are tabulated and reported only as "White" and "Nonwhite," making it difficult to ascertain precise rates for African Americans and other minorities.) African Americans may be experiencing high rates of diseases such as esophageal cancer and cirrhosis because they are unable to receive access to timely treatment for their alcohol or other drug dependence. Health problems related to alcohol and other drug use are likely to increase as a user continues to use.

The U.S. Surgeon General reports that the prevalence of cigarette smoking is higher among African Americans, blue-collar workers, and less-educated persons than in the overall population. In particular, 41 percent of African American men were smokers in 1987, as compared to 31 percent of White men. Recent research studies have identified the interaction effects of cigarette smoking with alcohol ingestion to increase the risk of cancer (32).

African Americans have one of the highest infant mortality rates of any group in the United States. In addition, many premature births, infant deaths, and infant diseases are related to alcohol or other drug use by the mother, and/or to the high rate of teen pregnancy. Epidemiological studies have demonstrated a greater susceptibility of African Americans to the harmful effects of prenatal alcohol exposure. Even when the infant of an alcohol- or drug-dependent mother survives, its physical health or mental abilities may be permanently damaged by exposure to alcohol or other drugs before birth.

African American intravenous drug users and their sexual partners run a high risk of contracting the Human Immunodeficiency Virus (HIV), which causes Acquired Immune Deficiency Syndrome (AIDS). Needles and other drug apparatus shared by intravenous drug users can be contaminated by this virus. In some areas, over half of all intravenous drug users who have been tested have been exposed to HIV. Of all AIDS cases among women in the United States, the majority are African American or Hispanic. A 1990 study conducted by researchers at the Federal Centers for Disease Control suggests that young African American women are dying of HIV infection at a rate 9 times higher than White women of the same age. In New Jersey alone, the death rate among African American women was more than 40 deaths per 100,000 persons in the population, compared with a rate of about 4 per 100,000 for young White women. If such trends continue, the study predicted that by next year AIDS would become the fifth-ranking cause of death among all women in the childbearing years nationwide. Researchers believe that most became infected either through drug use or through sexual contact with infected intravenous drug users. In some cities, most children with AIDS are young African American children of infected intravenous drug users.

In addition, mental health problems resulting from drug use are often identified among African American drug users. Some types of drug use are associated with a high rate of delirium and recurring violence; others can result in long-term brain damage, mental illness, and severe depression.

How does alcohol and other drug use affect African American communities?

Research has shown that African American neighborhoods with disproportionately large alcoholic populations demonstrate above average rates of overcrowded housing, juvenile crime, unemployment, and families on welfare (7). The economic, physical, and social environment itself may also encourage greater use of alcohol and other drugs. Thus, drug use and social problems may be interrelated in African American neighborhoods. The effects of alcohol and other drug use are intensified when other factors exist, such as high unemployment, poverty, poor health care, and poor nutrition.

Does the use of drugs other than alcohol contribute to juvenile delinquency among African American youth?

Although social scientists believe that more research on this subject is needed, some of their findings challenge popular beliefs about the relationship between juvenile crime and drug use.

For instance, delinquent behavior appears to begin before drug use. In other words, African American youth tend to use drugs other than alcohol after they

form the attitudes and adopt behaviors associated with delinquency (25). The most common crimes of young drug users tend to be nonviolent. These include drug dealing, shoplifting, petty theft, and "con games" (11). A 1990 study conducted in Washington, D.C. found that the vast majority of District residents charged with drug dealing in the late 1980s were African American males aged 18–29. As many as 1 out of 6 African American males born in 1967 were charged with drug distribution between ages 18 and 20. Two thirds of those arrested for drug dealing were legitimately employed, earning a median income of $800 per month. Proceeds from drug dealing, for those who sold on a daily basis, averaged $24,000 per year (31).

The relationship between drugs and crime in the African American community may be changing. Cocaine use, which has increased in some African American neighborhoods, appears to be associated with a greater propensity to commit crimes (11), whereas PCP is linked to violent behavior. In 1982, less than 12 percent of all African American homicides were related to criminal activities such as drug trafficking (26); by 1987, police in one major city identified more than half of the African American homicides as drug-related. Researchers have pointed out that African Americans who support drug-using lifestyles do so primarily by victimizing members of their own community (3).

Is alcohol a factor in criminal activity among African American youth?

Yes. The relationship between alcohol use among African American youth and crime is better documented than the relationship between other drug use and crime. Among African American youth, those who use alcohol are more likely to engage in delinquent behavior than those who do not drink (4). Alcohol use—rather than use of other drugs—is most decidedly linked to *violent* crimes in the African American community.

Among heroin addicts in Harlem, New York, researchers found that alcohol is used more often than any other drug before commission of a crime. In addition, heroin users are more likely to spend the proceeds of crime on alcohol than on any other drug (24).

Such research findings lead social scientists to believe that a reduction of alcohol use in the African American community may have a greater impact on crime than the reduction of any other form of drug use.

Do African American youth encounter barriers to effective treatment of alcohol and other drug use problems?

Yes. Low-income African American youth—and low-income Americans in general—face economic barriers to treatment for alcohol and other drug use.

These include lack of funds or insurance to pay for treatment, long waiting lists for admission to affordable programs, and lack of economic support to sustain them or their families during a typical 28-day inpatient treatment stay. Low-income single parents face particularly difficult barriers because of the lack of child-care options, possible loss of custody, and other threats to economic and family security posed by inpatient treatment.

Many communities are responding to these barriers by funding more treatment programs for low-income clients, by supporting outpatient alternatives to hospital stays, by advocating more effective treatment for alcohol and other drug users in correctional facilities, and by addressing the special needs of single parents.

Some analysts believe that African American clients of alcohol and other drug treatment programs face cultural barriers to successful completion of treatment (13). Authors have suggested that White treatment professionals lack the cultural sensitivity needed to work successfully with African American clients. Some of the same writers have also described major administrative problems experienced by programs that are designed to serve minority groups (16). There is no conclusive evidence, however, and some research studies of the 1970s suggest that African American clients of treatment programs tend to be younger, more strongly motivated, and more cooperative than other clients (7).

Can we prevent alcohol and other drug use among African American youth?

Yes. Long-term education and prevention programs, reinforced by messages in the mass media, have proven to be effective in reducing the incidence of some types of drug use problems among African American youth (1). More progress can be made when communities and families provide full support to local prevention efforts targeted at minority youth (29).

Does prevention of alcohol and other drug abuse in the African American community depend on major changes in economic and social conditions?

No. Positive factors preventing youth alcohol and other drug use already exist in nearly every African American community. As several authors note, most African American youth—even in low-income areas—escape from alcohol and other drug problems (21). Some of the protective factors appear to be remaining in school, strong family bonds, strong religious beliefs, high self-esteem, adequate coping and social skills, and employment. (3,14,17)

However, it is possible that reduction of alcohol and other drug use among African American youth may not occur without major changes in the social and

economic environment. Nevertheless, thousands of African American teenagers can be spared the destructive effects of alcoholism and other drug dependence. Communities must decide not to tolerate alcohol and other drug use by youth and to invest community resources in long-term prevention programs and activities.

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Resources For African American Programs

Books, Workbooks, Manuals, and Other Written Materials

Alcohol Abuse and Black America
This classic, written by F. Harper in 1976, includes chapters of discussion on the history and contemporary use of alcohol among African Americans. It describes theories of use, comparisons of use between urban and rural African Americans, counselling techniques, and training guidelines for professionals. It also discusses alcohol and its effects on the body, alcohol and crime, and special subpopulations. Availability: Douglass Publishers, Inc., P.O. Box 3270, Alexandria, VA 22302 (Cost $12.95), or check with your local librarian.

Alcohol and Drug Abuse in Black America: A Guide for Community Action
This 24-page booklet describes the status of alcohol and other drug abuse, as well as strategies for communities to use in efforts to turn around the problem. The booklet briefly describes the historical legal measures prohibiting African Americans from using alcohol and then encouraging drunkeness during holidays. Also, bootlegging, the failure of social norms to regulate appropriate alcohol use, and the problem of denial of abuse in communities beset by racism and poverty are discussed. Single copy free. Contact the Institute on Black Chemical Abuse, 2614 Nicollet Avenue South, Minneapolis, MN 55408, (612) 871-7878.

Alcohol Use Among U.S. Ethnic Minorities
This research monograph contains five major articles on alcohol use among African Americans, covering epidemiology, drinking patterns, and a comparative analysis. The articles are the result of a 1985 conference sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Findings suggest that race or ethnicity may be less important than sociodemographic characteristics in assessing levels of alcohol consumption. Single copy free. Contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852, (301) 468-2600. Ask for NIAAA Research Monograph 18.

Alcoholism in the Black Community
This article, written by Frieda Brown and Joan Tooley, summarizes historical precedents, patterns and practices, developmental issues, prevention and treatment strategies in a readable, short chapter. In: *Alcoholism and Substance Abuse in Special Populations* (Gary W. Lawson and Ann W. Lawson, editors). 1989. $39. Available from Aspen Publishers, Inc. 7201 McKinney Circle, Frederick, MD 21701, (800) 638-8437, or (301) 251-5233.

Black Alcoholism: Toward a Comprehensive Understanding
In this book, the authors present an overview of alcoholism among African Americans through a series of articles. They include discussions of etiology, pertinent research on treatment, problems associated with the prevention of African American alcoholism, the relationship of misuse of alcohol and alcoholism to mental health and the criminal justice system, and alcohol policy issues. T. Watts and R. Wright, eds. 1983. $32.50. Available from Charles C. Thomas, Publisher, 2600 South First Street, Springfield, IL 62717, (217) 789-8980.

Black Children of Alcoholic and Drug-Addicted Parents and a Model for Working with These Children
Written by Dr. Frances Larry Brisbane, the model described in this booklet was developed with Maxine Womble under the auspices of the National Black Alcoholism Council between 1985 and 1989. The model is designed for African American children, with particular emphasis on altering those factors that inhibit the use of traditional treatment or participation in groups of children of alcoholics. The 18-page booklet provides many examples for group facilitators. Contact the National Black Alcoholism Council, Inc., 417 S. Dearborn Street, Suite 1000, Chicago, IL 60605, (312) 663-5780.

Black Parenting: Strategies for Training
Written by Dr. Kerby T. Alvy, this book describes the unique context of African American parenting, compares it with White parenting attitudes and practices, and offers guidelines for effective African American parenting. Specific strategies for implementing parenting programs in African American communities are discussed. Contact the Center for the Improvement of Child Caring, 11221 Ventura Boulevard, Suite 103, Studio City, CA 91604, (818) 980-0903.

Development of Cultural-Specific Substance Abuse Prevention Programs for Black and Hispanic Populations: A Guidebook
The Guidebook reviews and evaluates 39 written and audiovisual resources for their cultural relevancy to the needs of African American and Hispanic populations. Although somewhat dated, the Guidebook is valuable when supplemented with more current materials and information. In its overview, it contains a framework for sociological and cultural factors to be considered in the evaluation

of culture-specific materials. Limited number of copies. $25. Available from the Prevention Resource Center Clearinghouse, 901 South Second Street, Springfield, IL 62704, (217) 525-3456.

Marketing Booze to Blacks
This 54-page book, written by George A. Hacker, Ronald Collins, and Michael Jacobson, analyzes the ways in which African Americans are unique targets of alcohol producers in the United States. This report documents the extent of alcohol problems among African Americans, and questions the alcoholic beverage marketers and producers who are intent upon expanding their sales and profits through massive advertising campaigns in the African American community, as well as appeals that include scholarship donations and sponsorship of African American History Month. The authors conclude that Unquestionably, alcohol producers (White-owned) and their ad agencies (many Black-owned) have remained indifferent to the severity of alcohol problems confronting Blacks. They add that Many Black civic and philanthropic groups have become addicted to the largesse of alcohol and tobacco producers. Published in 1987 by the Center for Science in the Public Interest (CSPI), the book covers the destructiveness of alcohol in the African American community; television, magazine, and billboard advertising; celebrity promotions; and recommendations for public action. $4.95, plus $.75 postage. A video production of *Marketing Booze to Blacks* will be available in 1990 from the Institute on Black Chemical Abuse (see below) and the Center for Science in the Public Interest, 1501 16th Street, NW, Washington, D.C. 20036, (202) 332-9110 (also see separate entry on CSPI). The book is available from CSPI.

"We cannot stagger to freedom."
This article by Denise Herd appears in the *Yearbook of Substance Use and Abuse*, Volume 3 (L. Brill and C. Winick, eds.), published in 1985. It traces the history of African Americans and alcohol in the American temperance and prohibition periods. It concludes that the total upturn in drinking problems among African Americans since the nineteenth century relates to patterns of racial oppression and exploitation stemming from the prohibition era rather than to changes in cultural or psychological norms. She contends that efforts to reduce alcohol problems among African Americans must take into account their general interest in political and socioeconomic betterment. $44.95. Available from Human Sciences Press, 233 Spring Street, New York, NY 10012, (212) 620-8000.

Substance Abuse Among Minority Youth: Blacks
This overview and research summary is the fourth in a series by Dr. Gregory Austin. Focusing on adolescent drug abuse and its prevention, the series is part of *Prevention Research Update*, a quarterly awareness service prepared by the Western Center for Drug-Free Schools and Communities. Austin discusses the implications of new research and also publishes abstracts of the major studies

cited. His goal is to help bridge the communications gap between the researcher, the practitioner, and the general population by disseminating research findings in an accessible manner. Single copies are free. Available from the Southwest Regional Educational Laboratory, 4665 Lampson Avenue, Los Alamitos, CA 90720, (213) 598-7661.

Winners, Vol. II and III
This culturally sensitive workbook by Darnell Bell is designed to be part of a comprehensive prevention effort. It encourages racial pride for African Americans and views self-esteem and a healthy self-concept as crucial. The two-volume workbook includes 102 creative writing activities, background information, and a sense of tradition and history through biographies of positive role models. Decision-making skills, feelings validation, and values clarification are also covered. Workbooks directed toward parents and communities are planned to supplement these volumes, which are directed toward youth. Contact Darnell Bell, 1576 E. King Jr. Blvd., Los Angeles, CA 90011, (213) 234-2350.

Organizations

Black Children of Alcoholic and Drug-Addicted Persons (B/COADAP)
This small but expanding organization provides mutual support for African American men and women who have grown up in households where one or both parents were alcoholic. It operates on a club model and is not a drop-in group, though new members are welcome. African American people wishing to join, establish a new chapter, or acquire further information should call or write Dr. Frances Larry Brisbane, 139 La Bonne Vie Drive West, East Patchogue, NY 11720; (516) 654-2378 or (516) 444-3168, or contact the National Black Alcoholism Council (listed below).

Center for Science in the Public Interest (CSPI)
This national consumer nonprofit advocacy and education organization recently initiated a Minority Health Project. The goal of the Health Project is to improve the health status of minority populations. They aim to build joint health promotion programs with other organizations, conduct research, and improve Federal policies and corporate practices on diet, alcohol, and tobacco. They also produce materials designed to publicize and reduce problems related to nutrition, alcoholic beverages, and cigarettes among African Americans, Hispanics, and other minorities. Contact the Center for Science in the Public Interest, 1501 16th Street NW, Washington, D.C. 20036; (202) 332-9110.

Cork Institute on Black Alcohol and Other Drug Abuse
Located at the Morehouse School of Medicine in Georgia, the Institute is primarily a training and research program designed to develop culturally specific curricula for alcohol and other drug use programs in medical schools and other public health programs. The Institute is building collections of printed

material relating to chemical dependency, treatment, and prevention in the African American community. The Director is Dr. Omowale Amuleru-Marshall. For more information, contact the director at Morehouse School of Medicine, 720 Westview Drive SW, Atlanta, GA 30310; (404) 752-1780.

Institute for the Advanced Study of Black Family Life and Culture, Inc.
This community-based nonprofit corporation specializes in the areas of scientific, educational, and cultural aspects of family life. The Institute is committed to the reclamation of African American culture, the reunification of the African American family, and the revitalization of the African American community. As an independent think-tank that is both a scientific research corporation and a human development/social sciences organization, the Institute is concerned about the presence of drug trafficking and drug-related activities in African American communities. They have issued a report, A Clear and Present Danger: The Effects of Drugs and Drug Trafficking on the Mental Health of Black Children and Families in Oakland, and other related reports. Request a catalog of materials, including training materials, from the Dissemination Division, Institute for the Advanced Study of Black Family Life and Culture, Inc., P.O. Box 24739, Oakland, CA 94623; (415) 836-3245.

Institute on Black Chemical Abuse (IBCA)
The Institute provides a range of services adapted to the African American community, including prevention, intervention, drug and alcohol information, aftercare, and training of healthcare professionals. The Institute has an internship program and a resource center. They publish a newsletter. A home-based program for severely dysfunctional African American families was recently initiated to help youth in trouble remain in the home and avoid institutionalization. Other IBCA programs focus on codependency, family violence, and community education. Training efforts include an IBCA Summer Institute that teaches an African American model of treatment and specific strategies for working with African American clients, including children of alcoholics. The Institute has recently published a manual, *Developing Chemical Dependency Services for Black People*, which passes along to others details of the IBCA Model and what has been learned about successful programs for the reduction of alcohol and other drug use in the African American community. Contact Peter Bell, Executive Director, Institute on Black Chemical Abuse, 2614 Nicollet Avenue South, Minneapolis, MN 55408, (612) 871-7878.

Multicultural Training Resource Center (MTRC)
Established in 1984 to provide culturally specific AIDS and alcohol and other drug use prevention service, MTRC's philosophy is based on the idea that prevention is a proactive process. It promotes the empowerment of people, families, and communities. MTRC provides information, technical assistance, and training. In addition, it develops materials to educate service providers. MTRC believes that a multicultural approach is necessary because drug use

patterns vary widely between and within cultural groups, illustrating the inappropriateness of any generic prevention model. Contact Ford Hatamiya, Multicultural Training Resource Center, 1540 Market Street, Suite 320, San Francisco, CA 94102; (415) 861-2142.

National Black Alcoholism Council (NBAC)
This organization has over 1,000 members in 20 chapters throughout the United States who work to raise the consciousness of the African American community about the impact of alcohol and other drug use and to represent African American concerns in national organizations. NBAC also publishes a semiannual newsletter, sponsors or cosponsors workshops and conferences (including the annual Black Alcoholism Institute), and supervises a national speakers' bureau. Contact NBAC, 417 Dearborn Street, Chicago, IL 60605; (312) 663-5780.

National Clearinghouse for Alcohol and Drug Information (NCADI)
This Federal resource center for alcohol and other drug information is sponsored by the Office for Substance Abuse Prevention of the U.S. Department of Health and Human Services. NCADI distributes print and audiovisual materials and offers limited quantities free of charge. The Regional Alcohol and Drug Awareness Resource (RADAR) Network comprises resource centers in almost every State NCADI will refer you to one in your area. NCADI also offers database services and, for a $15 annual handling fee, a subscription to *Prevention Pipeline*, the bimonthly news service of the alcohol and other drug field. *Pipeline* is a forum, a news bulletin, and a research alert. Write for a free publication catalog. Contact NCADI, P.O. Box 2345, Rockville, MD 20852; (301) 468-2600 or 1-800-SAY-NO-TO (DRUGS).

OSAP Community Prevention Assistance Services
Operated under contract to the Office for Substance Abuse Prevention (OSAP), this program provides conference planning, referral services, and assistance to national, State, and local organizations. Its purpose is to help plan and conduct activities designed to prevent alcohol and other drug problems. The goal of the program is to identify the most promising prevention strategies, based on up-to-date research, and to help organizations in carrying out strategies that are appropriate for their target audiences. Contact Elaine Brady Rogers, TA Systems Manager, 8201 Greensboro Drive, Suite 500, McLean, Virginia 22102; (703) 556-0212.

Office of Minority Health Resource Center (OMH-RC)
This office brings health information and services to minorities and serves as a repository for health education materials. A computer database on African Americans, Hispanics, Native Americans, and Asian Americans/Pacific Islanders focuses on their six health priority areas: cancer, diabetes, heart disease and stroke, infant mortality, alcohol and other drug use, homicide, suicide, and

unintentional injuries. They publish a newsletter, Closing the Gap, and resource lists, including one on health materials for African Americans. Call the Resource Center at 1-800-444-6472 or (301) 587-1938, or write OMH-RC at P.O. Box 37337, Washington, DC 20013-7337.

People of Color Against AIDS Network (POCAAN)
POCAAN is a multiracial, educational coalition that provides training and works with existing AIDS programs on issues pertaining to people of color. It develops materials on AIDS education, such as comic books and pamphlets, for minority groups. Their pamphlet AIDS in the African American Community summarizes the important facts. Their poster series, Famous Last Words, strikes at myths such as AIDS is a White man's disease. POCAAN is made up of individuals and organizations. For more information call P. Catlin Fullwood, Director, 105 14th Ave., Suite 2D, Seattle, WA 98122; (206) 322-7061.

Grants and Other Funding Opportunities

Prevention Demonstration Grants Targeting Youth at High Risk
The Office for Substance Abuse Prevention (OSAP) encourages applicants from community-based organizations to develop and test innovative models of prevention and treatment of alcohol and other drug use among high-risk youth, especially those that test primary prevention and early intervention models. Demonstration grants will be awarded to those community-based programs that develop and evaluate approaches addressing the following objectives:

- to decrease the incidence and prevalence of alcohol and other drug use among high-risk youth;
- to reduce the risk factors for using alcohol and other drugs as they impact on individual high-risk youth, and on the environments in which high-risk youths and their families function;
- to increase resiliency and protective factors within high-risk youth and within high-risk families and communities to reduce the likelihood that youths will use alcohol and other drugs;
- to coordinate and integrate the non-use messages and activities of the many human service systems and other social influences affecting high-risk youth into comprehensive, multilevel prevention communities;
- to increase the availability and accessibility of prevention, treatment, and rehabilitation services for these populations; and
- to reduce the severity of impairment and promote the rehabilitation of youths already using alcohol and other drugs.

Model Projects for Pregnant and Postpartum Women and Their Infants
In a joint effort, OSAP and the Office of Maternal and Child Health are funding service demonstration grant projects that focus on prevention, education, and treatment. Successful applicants will propose service projects that include promising models or innovative approaches toward the prevention of fetal exposure to alcohol and other drugs, as well as projects that coordinate existing community services with new or expanded services. OSAP seeks the development of a continuum of therapeutic programs that integrate comprehensive supportive services, which include health, education, voluntary, and other relevant community-based organizations and service systems. Proposed programs should also increase the availability of services, decrease alcohol and other drug use, and reduce the effects of maternal alcohol and other drug use on infants. Proposed projects should address one or more of the following objectives:

- promote the involvement and coordinated participation of multiple organizations in the delivery of comprehensive services for alcohol- and other drug-using pregnant and postpartum women and their infants;
- increase the availability and accessibility of prevention, early intervention, and treatment services for these populations;
- decrease the incidence and prevalence of alcohol and other drug use among pregnant and postpartum women;
- improve the birth outcomes of women who used alcohol and other drugs during pregnancy and to decrease the incidence of infants affected by maternal alcohol and other drug use; and
- reduce the severity of impairment among children born to women who use alcohol and other drugs.

Films and Videotapes

A Thin Line: Recognizing Cultural Differences and Working with Black Chemically Dependent Clients
Produced by the Institute on Black Chemical Abuse, this film focuses on training counselors to work more effectively with African American clients in treatment. 1989. $175, plus $3 shipping and handling. Contact David Grant or Sandy Vadnais, Institute on Black Chemical Abuse, 2614 Nicollet Avenue South, Minneapolis, MN 55408; (612) 871-7878.

Long Road Home
This film portrays the development of a drinking problem in a young African American family man named Willie. The origins of his drinking and its impact on his family life are described, as are the improvements resulting from his successful treatment. Intended mainly for rural populations, the film attempts

to show the special character and problems of rural African American culture. 20 minutes. 1977. $250, sale. $30, rental. Contact Elizabeth Peters at the South Carolina Commission on Alcohol and Drug Abuse, 3700 Forest Drive, Suite 300, Columbia, SC 29204; (803) 734-9559.

Straight Talk
This first-person story describes drug addiction as a desperate attempt to feel like the king of the mountain. Former addict Roland Abner's straight talk describes what life is like when centered on drugs. He states emphatically that the wretchedness of addiction is not exclusive to the poor or downtrodden. Narcotics is an equal opportunity destroyer, he says. For teenage and adult audiences and healthcare professionals. 24 minutes. Film, $475; video $395. Rental, $75. AIMS Media, 6901 Woodley Avenue, Van Nuys, CA 91406-4878; (800) 367-2467

Highlights: Expert Advisory Roundtable on African-American Issues, Morehouse College of Medicine, August 31–September 1, 1989
A panel of African-American experts, psychologists, health care professionals, and policymakers explores issues relevant to African-American families and communities in a videotape produced by the Office for Substance Abuse Prevention. This video is available as part of the audiovisual free-loan program operated by the National Clearinghouse for Alcohol and Drug Information. For more information, call NCADI at 1-800-SAY-NO-TO (DRUGS), or write: NCADI, P.O. Box 2345, Rockville, MD 20852.

OSAP

Printed by the Office for Substance Abuse Prevention
and distributed by the
National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20852

DHHS Publication No. (ADM) 90-1672
Printed 1990